U.S. ARMY SERVICE FORCES

RECONDITIONING CONFERENCE
ON THE
CONVALESCENT HOSPITAL RECONDITIONING PROGRAM

3-4 JANUARY, 1945
SCHOOL FOR PERSONNEL SERVICES
LEXINGTON, VA.

PROGRAM

WEDNESDAY

3 January 1945

MORNING SESSION

Colonel Thorndike Presiding

INTERMISSION

INTERMISSION

AFTERNOON SESSION

Lt. Col. Barton Presiding

INTERMISSION

THURSDAY

4 January 1945

MORNING SESSION

Major Gwynn Presiding

INTERMISSION

AFTERNOON SESSION

Major Gwynn Presiding

INTERMISSION

EVENING SESSION

Major Briscoe Presiding

ROSTER

COL. HOWELL BREWER	Commanding Officer, Fort Story Convalescent Hospital, Va.
COL. PHILIP L. COOK	Commanding Officer, Welch Convalescent Hospital, Daytona Beach, Fla.
COL. G. PHILIP GRABFIELD	Director of Reconditioning, Headquarters, First Service Command.
COL. A. H. SCHWICHTENBERG	Director, Hospital Division, SGO, Washington, D.C.
COL. EDWIN R. STRONG	Chief of Reconditioning, Camp Carson Convalescent Hospital, Colorado.
COL. AUGUSTUS THORNDIKE	Director, Reconditioning Consultants Division, SGO, Washington, D. C.
LT. COL. W. R. ALBUS	Director of Reconditioning, Headquarters, Sixth Service Command.
LT. COL. WALTER E. BARTON	Assistant Director, Reconditioning Consultants Division, SGO, Washington, D. C.
LT. COL. CONDICT W. CUTLER	Consultant in Surgery, Headquarters, First Service Command.
LT. COL. N. K. JENSEN	Director, Reconditioning Department, School for Personnel Services.
LT. COL. ROBERT L. PRESTON	Director of Reconditioning, Headquarters, Fifth Service Command.
LT. COL. GEORGE STINE	Chief of Reconditioning, Convalescent Hospital, Lovell General and Convalescent Hospital, Fort Devens, Mass.
MAJOR WILLARD P. ASHBROOK	Chief of Physical Reconditioning, Headquarters, Fifth Service Command.
MAJOR BEN L. BOYNTON	Director of Reconditioning, Headquarters, Third Service Command.
MAJOR EMIL W. BEELMAN	Chief of Physical Reconditioning, Headquarters, Second Service Command.
MAJOR WILLIAM S. BRISCOE	Reconditioning Consultants Division, SGO, Washington, D. C.
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MAJOR HENRY B. GWYNN	Reconditioning Consultants Division, SGO, Washington, D. C.
MAJOR WILLIAM E. HURST	Welch Convalescent Hospital, Daytona Beach, Fla.
MAJOR IRVING R. JUSTER	Mitchell Convalescent Hospital, Camp Lockett, California.
MAJOR DONALD P. KEEL	Wakeman General and Convalescent Hospital, Indiana.
MAJOR A. F. LIPTON	Technical Division, SGO, Washington, D. C.
MAJOR ROBERT S. LOUGH	Director of Reconditioning, Headquarters, Seventh Service Command (Now attending school)
MAJOR EDWIN M. LOYE	Hospital Division, SGO, Washington, D. C.
MAJOR JAMES E. A. LUMLEY	Headquarters, Third Service Command.
MAJOR CECIL MORGAN	Fort Story Convalescent Hospital, Va.
MAJOR JAMES R. PATRICK	Deputy Director of Reconditioning, Headquarters, Ninth Service Command.
MAJOR C. H. PETERSON	Walter Reed General Hospital, Washington, D.C.
MAJOR LOUDON C. REID	Chief of Reconditioning, Wakeman General and Convalescent Hospital, Indiana.
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MAJOR HERMAN SELINSKI	Wakeman General and Convalescent Hospital, Indiana.
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MAJOR JAMES H. SMITH	Director of Reconditioning, Headquarters, Eighth Service Command.
MAJOR RANDOLPH W. WEBSTER	Wakeman General and Convalescent Hospital, Indiana.
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MAJOR ROBERT T. WILKINSON	Brooke General and Convalescent Hospital, Texas.
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1ST LT. JAMES E. NAGLE	Wakeman General and Convalescent Hospital, Indiana.
1ST LT. ALEX NORTH	Special Service Division, New York, N. Y.
MR. DAVID KAHN	Stenographic Reporter, Washington, D. C.
MISS RHODA D. LESTER	Chief of Occupational Therapy Branch, Headquarters, Third Service Command.
MISS H. ELIZABETH MESSICK	Reconditioning Consultants Division, SGO, Washington, D. C.
MR. JOHN A. MORROW	Reconditioning Consultants Division, SGO, Washington, D. C.
MR. ROY A. NEWKIRK	
MR. SILAS M. RANSOPHER	Reconditioning Consultants Division, SGO, Washington, D. C.
MR. ELMER P. WILLIAMS	Visual Aids Coordinator, Headquarters, Third Service Command.
MISS ELIZABETH ROMEL	Reconditioning Consultants Division, SGO, Washington, D. C.
MISS ELEANOR C. VINCENT	Red Cross Headquarters, Washington, D. C.
MR. ROBERT H. WILSON	Roanoke, Virginia.

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MR. E. W. PENNOCK

PROCEEDINGS OF THE CONFERENCE

January 3, 1945.

Morning Session.

COL. QUARTERMAN: Col. Thorndike, guests, and members of the Conference: it is with great pleasure on the part of the School and the faculty and particularly on behalf of Major General Joe N. Dalton, who is the supervising head of the School for Personnel Services, to welcome you here to Lexington for your Convalescent Reconditioning Conference.

We have, at the School, been tremendously interested in that program. I enjoyed a trip this summer to practically all theaters of operation and was amazed at the interest that was shown in reconditioning by so many theater surgeons and commanding officers of hospitals all the way from Casa Blanca through the Middle East, Persian Gulf, India, Australia, and New Guinea. As a layman, I could see the necessity for reconditioning, the interest in it, and the benefits derived from it. In Biak, off New Guinea, I saw a reconditioning batallion with a medical major in charge, with a fine layout right along the shore, with class rooms for the educational reconditioning and just back of it across the road in the sand an athletic field, where they were already doing this job without having the benefit of much training or advice on programs or procedures. They were doing a good job, and were interested in how to do a better job. It stimulated me to try to do something about it when I got back.

I do hope this Conference will be of tremendous benefit to you and to all of the Service Commands and will give you some ideas that you did not have before.

I hope you will make yourselves at home. Call on us for any help that we can give you. Thank you.

COL. THORNDIKE: Thank you, Colonel Quarterman. I am always glad to hear something good said about the Southwest Pacific Theater because that is where my time has been spent, and also a mention of Biak Island, because that is where my old unit now is.

We will now adjourn to Room 4, which is directly overhead, to view the film 8-2070, "Reconditioning Convalescents for Return to Duty".

(Recess for the showing of the film.)

COL. THORNDIKE.(Presiding): Will the conference come to order.

I am going to ask Major Lipton of the Surgeon General's office to talk briefly and distribute the proposed manning tables for personnel for convalescent hospitals. He wants to get these into your hands nowso that you may have a few moments to study them sometime before he speaks this afternoon.

MAJOR LIPTON: It is Colonel Thorndike's desire that each one of the service command surgeons and hospital commanders take one copy of a thousand bed and a two thousand bed table and, at your convenience, study it before 1330 today in order that we may discuss this and get your recommendations on the present draft.

I would like to call your attention to the fact that this table has not been authorized by higher authorities yet.

COL. THORNDIKE: This is for service command representatives and convalescen hospital commanders or their representatives.

As the next talk involves secret information, I will ask all civilians to leave the room.

(Talk by Col. Schwichtenberg not reported.)

COL JENSEN: Will the Class 1 and 2 patients now in general hospitals continue to be handled in converted barracks?

COL. SCHWICHTENBERG: The converted barracks in most instances can be made into hospital wards. Some Class 3 patients can live in the advanced reconditioning section if the barracks are improved. - I -

MAJOR PATRICK: Can the facilities on hospital grounds previously used for parallel training now be used by the hospital?

COL. SCHWICHTENBERG: All parallel training facilities may be taken over by the hospital. If it proves necessary to use them later, prefabricated buildings will be provided.

COL. GRABFIELD: Can The Surgeon General's office expedite our requests for building improvement for such things as paint and the like? It now takes us three to six months to get approval.

COL. THORNDIKE: I would like to reply to that question. Ten days ago in a conference with General Styer, in which the Chief of Engineers was present, the order was given to expedite painting and improvement.

COL. GRABFIELD: In my experience there has not even been heat, in some instances, provided in barracks. What about getting authority for relining buildings?

COL. SCHWICHTENBERG: For a time Spartan simplicity characterized the army's policy. It motivated the engineers. Now, General Somervell has revoked that policy as far as it applies to hospitals. He has stated that they must be made livable. Paint, landscaping, and the like are included in that order.

MAJOR GWYNN: Certain advanced reconditioning sections are remote from general hospitals. Should they now be abandoned?

- I -

COL. SCHWICHTENBERG: That will be a matter for individual exploration. General Marrietta at Walter Reed, plans to close Beltsville, because it is too remote, and because he does not have enough Class 1 and 2 patients, that may be the experience of others.

CAPT. BLAINE: Moore General Hospital is a tropical disease center. Will it continue to use its advanced reconditioning section?

COL. SCHWICHTENBERG: Exceptions for specialties will undoubtedly have to be made.

COL. THORNDIKE: In a conference yesterday with Dr. Ginsberg it was stated that it was not contemplated to separate patients from special centers for tropical disease, rheumatic fever, amputations, and the like.

Col. Barton, will you talk about your recent conference on furnishings for convalescent hospitals?

COL. BARTON: In a recent conference, the Technical Division in the Surgeon General's office agreed to provide furnishings for convalescent hospital recreation buildings, based upon the present hospital day room plan. Such furnishings include easy chairs, davenports, lamps, rugs, and the like.

MAJOR PATRICK: How do you get them?

COL. BARTON: I am going to ask Captain Allen to answer that question.

CAPT. ALLEN: Medical Supply List No. 10-24 will be out a few days after this conference. It will contain complete authority, and the basis for requisition of such furnishings. We are not publishing it until after the conference, in order that we may have included in it all of the ideas you may bring up today and tomorrow.

COL. SCHWICHTENBERG: In concluding this talk, I would like to add two more thoughts. First, it is most important to get physiotherapy facilities in operation at once. In one neurosurgical center there are some 200 patients who could go to a convalescent Hospital if physiotherapy were available. Neurosurgical beds are very tight. It, therefore, behooves us to immediately put in operation facilities for treatment.

Secondly, I hope you will bring up for discussion what is wanted in the way of American Red Cross facilities for recreation.

LT. COL. BARTON (Presiding): The next topic on the program will be presented by Col. Thorndike.

THE MISSION AND PROGRAM OF RECONDITIONING IN THE LIGHT OF CHANGING FACTORS IN THE MILITARY SITUATION

COL. AUGUSTUS THORNDIKE, MC,
Director, Reconditioning Consultants Division,
Office of The Surgeon General.

Clearly enunciated at the conference at Schick General Hospital on 21 and 22 March 1944, the mission of reconditioning remains. At that time attention was focused at the return to duty of the greatest number of patients in the shortest possible time. At this time such policy still applies in the station and regional hospitals. The mission and program to appear in the forthcoming manuals will provide for all conditions resulting from war and casualties but will require careful planning to obtain the optimum program for either the CDD or those returned to duty, whether originating in overseas theater or in the zone of interior. In fact, the doctrine is so presented that it will likewise be applicable in that period of adjustment after the defeat of Germany. Fundamentally the objectives of reconditioning remain the same, come hell or high water, namely, the salvage of manpower whether for military or for civilian purposes. It is appropriate to quote Major General Ray E. Porter, WDGS, "We owe a debt to our sick and wounded soldiers, to their families, and to future America which must be met if we are not justly to sacrifice all confidence in our leadership------Their loss, or their impaired usefulness will be an irreparable loss to our country."

One is fully cognizant that many factors influence fundamental changes in policy in wartime. Perhaps a review of some of the more important ones is indicated. The military tactical situation changes overnight, for example, the recent German break through in Belgium; exigencies arising in the military service or some branch or service, for example, the medical evacuation speed-up causes drastic changes in our policies covering general hospital care of the ambulant patient; and a high rate of loss in military manpower causes the transfer of trained able-bodied men from all branches of the services into the Ground Forces--even from the Medical Department. When carefully considered the War Department frames its policies on all such vital statistics. War is greedy, its appetite for manpower vacillates! Let us consider the policy on discharge from the service for physical disability. One recalls the large numbers that were being lost to the Army in early 1943 until WD Circular 293 provided for the retention of limited service personnel. MR 1-9 was amended lowering the standards of physical fitness and WD Circulars 100, 161, 164 and 212, 1944, all implemented a plan for the retention of limited assignment personnel. However, it soon became apparent that there is a limit to the number of limited service soldiers an Army can absorb. It seemed as if that limit had been reached and the War Department published WD Circular 370, 1944, rescinding its previous circulars. Reconditioning blossomed during the era of limited service retentions and had some part to play in returning some of these to full military duty and other to limited duty that otherwise might have been lost to the service. It played a part in the reduction in the discharge rate. Policies relating to conservation of military manpower will continue to fluctuate as exigencies of the military service require. Be prepared and ready to adjust your reconditioning programs to existing policies.

The recent letter of The President to the Secretary of War concerning his desire to extend to the disabled returning soldier, the advantages of vocational guidance, pre-vocational training and resocialization has caused an impetus which provided personnel allotments for the Convalescent Hospital Program. ASF Circular 419, 1944, RTPI 8-1, Equipment List, and Supply List Nos. 10-23, 10-24, 10-25 all pertain to that program. With the change in character of general hospital patients the flow of patients to the Convalescent Hospitals must be accelerated and with the removal of Class 3A, Class 2 and Class 1 patients from General Hospitals, the reconditioning program will be given to Class 4 and 3B and 3C there only. Adjustments in personnel will have to be made and an amendment to ASF Circular 73, 1944, is now in preparation which will provide more personnel.

Such changes in policy affect the reconditioning program. TM 8-290, TM 8-291, TM 8-292, Training Film 8-2070 (not to be shown to patients), TB Med 80, 1944, WD pamphlet 21-17, and the pamphlet, "He's Back", represent the doctrine and have been prepared to provide sufficient source material to fit the program under any existing policy of the War Department. The program must be flexible to suit all types of patients; reconditioning personnel must be alert and imaginative to fit the optimum program to the needs of patients whatever policy change might appear. The training manuals will be published and distributed to all Medical Department officers. Reconditioning will be included in the curriculum of ASF training centers under the Medical Department starting the first of February. At that time of distribution it will be appropriate to review with the Medical Corps officers in your hospitals, TF 8-2070. It is well to emphasize that that film represents the doctrine of The Surgeon General and, further, that it has been shown in The White House, to the Veterans' Administrator and his staff, and that it will be shown to influential civilians at posts of the American Legion. The result of these showings will be that many visitors to your general hospitals will look for the optimum program for Class 4 and 3B and C in your general hospitals and Class 3A, 2 and 1 in your convalescent hospitals. The same program will not fit the patient returning to duty that fits the potential CDD, the program varies in general, regional and station hospitals but find and execute the optimum program for all patients requiring more than ten days hospitalization. It must be a balanced program emphasizing education and information for the bed patient, with TM bed exercises only, and recreation and increasing the intensity of physical reconditioning as the patient progresses to Class 2 and 1. The Convalescent Hospital program will be discussed in detail by later speakers, but the basic doctrine to be distributed 1 February will likewise apply there.

In conclusion it is important that all personnel concerned with reconditioning realize that the mission of reconditioning remains as before and that its primary concern is with the salvage of manpower whether reconditioned for military or civilian pursuit. It is further important to emphasize that the program will vary to suit different types of patients, whether overseas casualty or zone of interior regional hospital case. The doctrine as presented contains adequate source material to provide the program required for any type of hospital. ASF Circular 419, 1944, describes the more extensive program for convalescent hospitals but basic doctrine likewise will apply here.

It is essential to indoctrinate all medical officers in all ASF hospitals, some of whom even now do not comprehend the importance of directives. The President, the Secretary of War, the Chief of Staff and Commanding General, ASF, are all vitally interested in this program and its influence on the welfare of our sick and wounded. Directives have placed the responsibility for the execution of this program in the Commanding General of each Service Command. Let this execution result in the optimum program!

COL. BARTON: Discussion on Col. Thorndike's paper and my own will be postponed until the time indicated on your program.

I shall talk on the subject:

THE CONVALESCENT HOSPITAL RECONDITIONING PROGRAM

LT. COLONEL WALTER E. BARTON, MC.
Asst. Dir., Reconditioning Consultants Division.
Office of The Surgeon General.

"When a man enters the Army, the military training program prepares him physically and mentally for his duties as a soldier. Military drill, marches, and physical training develop strength and stamina. Special courses and field problems provide information and knowledge that enable him to perform successfully as a soldier. When his training is completed he should be in excellent physical condition and should possess the mental attitudes necessary to the effective soldier.

"The soldier who has been rendered inactive because of wounds or illness loses his efficiency. His physical strength deteriorates. Worry about himself and concern over personal affairs contribute to a loss of confidence which may result in apathy and indifference. This actually retards recovery and often produces unfortunate mental attitudes which result in ineffectual service or maladjustment to either military or civil environment.

"The needs of the armed forces demand maximum conservation of manpower. Each day that recovery of patients is delayed represents a loss of man hours in support of the war effort. If the convalescent soldier is to realize the greatest possible benefit from Army medical services, his physical, mental, and emotional needs must be considered. Therefore, recognizing this responsibility to the soldier and to the war effort The Surgeon General has established reconditioning as a part of professional medical care.

"The purpose of the Reconditioning Program is to accelerate the return to duty of convalescent soldiers in the highest state of physical and mental efficiency consistent with their capacities and the type of duty to which they will be assigned. Or, if the soldier is disqualified for further military service, the Reconditioning Program must provide for his return to civilian life, conditioned to the highest possible degree of physical fitness, well oriented in the responsibilities of citizenship, and prepared to adjust successfully to social and vocational pursuits. The mission is accomplished by a coordinated program of Educational Reconditioning, Physical Reconditioning and Occupational Therapy."

These remarks, taken from the Training Manual 8-290, Educational Reconditioning, state the mission of reconditioning. Attention has been called to the President's letter of 4 December 1944, in which he stated his desire that no overseas casualty be discharged from the armed services until he has received the maximum benefits of hospitalization and convalescent facilities which must include physical and psychological rehabilitation, vocational guidance, prevocational training and resocialization. Paragraph one of ASF Circular 419, 22 December 1944, is a partial step toward achievement of those objectives.

HOW WILL THE MISSION BE ACCOMPLISHED?

Understanding by the Staff of the concept of the "ultimate" done for patients must begin with a genuine interest in the welfare of the individual patient. Over and beyond excellent medical and surgical care, we must assist the soldier through the difficult transition from Army life to acceptance of a role of further service to the war effort and to country as a citizen. It is an obligation of the staff to understand the psychology of the man convalescing from disease and disability, and what is more important the attitudes, resentments and bitterness so often seen in the overseas casualties. An individualized approach directed toward the particular needs of each patient is essential to the achievement of vocational guidance and resocialization.

An overview of the entire program is greatly aided by the use of training film 8-2070; and the training manuals with which every staff worker should be thoroughly familiar. Attendance in the appropriate reconditioning training courses at the School for Personnel Services or at Fort Lewis is imperative if broad vision and understanding is to be achieved.

Understanding by the patient of the responsibilities he shares is also indispensable. Reconditioning is not some kind of glorified amusement program put on by a grateful country to do "something for the boys".

An initial orientation will quickly outline for the convalescent patient what is expected of him. The pamphlet, "New Horizons", placed in his hands will help but it must be supplemented with information that will explain how physical and occupational therapy and remedial exercise provide a means to develop motion and strength in a weakened part, and how essential physical fitness can be to successful living. If the soldier understands the aptitude tests are to help him wisely choose an occupation and the vocational guidance courses explore the wisdom of such a choice, he will undoubtedly work toward a goal.

Comfortable, attractive surroundings, understanding leadership and a program that stresses what he likes will aid materially. Wholesome planned recreation will win his enthusiasm and insure more hearty cooperation on the serious aspects of rehabilitation.

Showmanship should not be neglected in presentation of subjects to patients. For example, one might give a lecture to men suffering from psychoneuroses on the problems they may expect to face on return home. How much more meaningful the lesson becomes if the instructor dramatizes it! One patient seated at a desk is asked to take the part of the employer and another to enact the roll of the man newly discharged from the Army seeking a job. The problems brought out by similar devices encourage patient discussion and the lessons learned are those of experience and of their own making.

Understanding by the public is also fundamental, for veterans live their lives in a dynamic environment composed of people whose attitudes exert a helpful or hindering force upon their rehabilitation. Good publicity focused on the accomplishments in a convalescent hospital will help. More than this, a deeper understanding is required. This necessitates both good public relations and instruction of the public. In the latter responsibility you may expect outside assistance. The ASF weekly CBS radio broadcast on Saturday afternoon entitled "Assignment Home" comes to grips with these problems. Books like "Veteran Comes Back", "Psychology for the Returning Serviceman" and pamphlets like "He's Back", movies like the forthcoming "Tomorrow is Here" and the OWI sponsored advertisements in the daily press offer further assistance.

FUNCTIONAL ORGANIZATION

An efficient organization will mobilize the available resources into a meaningful program. In ASF Circular 419, 1944, four administrative sections are indicated for reconditioning activities on charts 1 and 3.

1. The Neuropsychiatric Section may, it is anticipated, constitute 40% od the total patient group. For these the convalescent reconditioning program constitutes their only treatment. This is in contrast to medical and surgical patients who have received their definitive treatment elsewhere and hence come only for convalescent care.

2. The Primary Reconditioning Section has been so designated as it may be expected to be made up chiefly of Class 3 patients, the majority of whom will be convalescent orthopedic and neurosurgical cases. It is estimated that 40% of this total will fall into this group.

3. The Advanced Reconditioning Section is intended to prepare Class 1 and 2 patients who can meet the minimum physical standards of MR 1-9 for return to duty. Under current discharge policies probably only 20% of the total patient group will be headed for further service, all others will be in preparation for return home.

4. The Convalescent Training Section, described on charts 2 - 4 and 5 of ASF Circular 419, 1944, was elaborated to facilitate the operation of the program of convalescent treatment as distinct from medical, surgical and psychiatric treatment.

It coordinates the individual counselling testing and guidance program with those of education, orientation, vocational guidance shopwork, occupational therapy and physical reconditioning.

Organization Chart One (ASF Circular 419, 1944) will not serve as an operating organization Chart for a hospital, as any one with an experienced eye can tell at a glance. It "blows up" the features peculiar to convalescent reconditioning.

PERSONNEL

Others more qualified than I, will supply this conference with specific details and will discuss personnel problems tomorrow. Only a few points need be made at the outset.

All personnel continues to be granted to service commands in bulk allotment. The needs of convalescent hospitals have been included in new personnel allotments. No overall grant of personnel for a convalescent hospital should be expected. Personnel must be secured from within the service command. If it can be justified, requisitions for additional personnel may be submitted to the Military Personnel Division. Requests for assistance in the procurement of instructor personnel with particular qualifications may be submitted to the Director of Military Personnel, SGO. The best source of personnel will continue to be from the patient in hospitals, for returned combat men are most desirable for work in the program. Manning tables for the convalescent training section and for the hospital have been provided you as guides to requirements.

The neuropsychiatric treatment activities demand special personnel. Chart 1 (ASF Circular 419, 1944) calls for psychiatrists, clinical psychologists and psychiatric social workers in the Receiving Division. Their function is to screen and route to a receiving battalion the NP cases who come as direct admissions from points of debarkation. Attention was previously invited to the fact that NP's receive their definitive treatment in a convalescent hospital, therefore one psychiatrist must be provided for each 100 patients; one clinical psychologist for each 200, and one psychiatric social worker for every 50 patients. This staff will carry on the necessary individual and group work and must be kept free from other distracting duties.

Expanded physical therapy departments, extra dentists, and an occupational therapy department have been provided.

The Convalescent Training Section requires the usual type educational reconditioning officers and instructors as well as personnel for counselling, classification and specialist instructors in the vocational guidance courses.

Upon the fitness of the Chief Reconditioning Officer and of the Chief of the Convalescent Training Section will rest the success of the entire program. It is essential therefore that really outstanding men be assigned this responsibility. The quality of instructor personnel should be high with retention of those who combine technical skill with a genuine interest in people.

PROGRAM

The importance of an initial orientation of the individual patient to the program and his responsibilities in it has been stressed. Counsellors will offer guidance and assistance in the planning of the individual's schedule and will follow his progress. Educational reconditioning will provide the usual services of information, orientation, discussions, guest speakers, special classes, etc. In addition it will provide vocational testing, vocational guidance shopwork and occupational information, and vocational guidance. Physical reconditioning and occupational therapy will bring their special contributions much as in the general hospital.

Recreation, however, assumes a greater relative importance in a convalescent hospital when compared to other hospitals. Entertainment movies, shows, concerts, dances, outings to points of interest, fishing trips, horseback riding and recreative games and sports should be available, in full measure.

The patients in the Primary Reconditioning Section will require physical therapy and occupational therapy and special corrective exercise built into their program.

The Advanced Reconditioning Section patients heading for duty will follow the doctrine set forth in TF 3-2070, in ASF Circular 217 and in the training manuals, TM 8-290 and TM 8-292.

The Neuropsychiatric program is outlined in TB Med 80 and 103. Individual and group therapy will work if given a chance. The Navy, with more than two years of neuropsychiatric reconditioning experience finds 3 months the optimum length of time required to successfully treat their men. We are suggesting for the present an average of sixty (60) days before disposition. The Army Air Forces report that more than 90% of officers and 80% of enlisted men are being returned to duty from the Convalescent Hospital at St. Petersburg, Florida, where a similar program is in operation.

SUPPLIES

Physical Reconditioning supplies are procurable upon requisition using Medical Supply List Med 10-25.

Occupational Therapy Supply List (entirely revised) Med 10-26 will be issued as soon as 75% of the materials are in the depot. It is believed now that this will be approximately 1 February 1945.

Educational Reconditioning equipment is available from TA 8-5 for the advanced reconditioning section, from the special TA vocational guidance shop lists furnished service commands a few days ago, and from a supply list to be issued in a few more days. There will be many omissions and revisions in the latter two lists. In the interest of immediate action, it was decided to let them be issued at once and hold final publication until after field testing brought errors to light. Film libraries, Information and Orientation Division materials, public address systems, and bicycles are some of the other items that may be secured.

SUMMARY

There are so many things that might be included in the convalescent reconditioning program it is essential not to build a sort of three ring circus which patients attend with the abandon and lack of purpose of the child spectator.

Let the true purpose be kept clearly in mind all the time. Planned convalescent treatment demands a lot of hard work of patients--for example, a man with limitation of motion and strength in an injured arm. Through physical therapy and laborious remedial exercise, gradually a useful and functioning arm may result and the man be headed back for duty. Technical assistants are at the doctors disposal to take off his shoulders the burden of detail in carrying out this restoration.

Many other returned soldiers will be anxious, irritable and resentful and will have complicating attitude reactions. It is our job to provide them with a means to help themselves find peace of mind and an acceptance of the new role they must assume as veterans. Motivation and incentive must be supplied. It is believed that the process of reeducation and readjustment need not be left to random chance but may follow some such plan as set forth in that outlined for the convalescent hospital.

COL. BARTON: This time has been set aside for your questions.

MAJOR BOYNTON: What about funds for Convalescent Hospital? Request was made in September for $30,000. Still no money. Possibly Col. Brewer ought to speak on this point.

COL. BREWER: In the beginning, I asked for $3500. Then I submitted an order for $30,000 to the Hospital Fund and it went back through channels. I just received it before I left for this conference. They wanted an itemized cost of what the money was going to be used for. It would be very difficult, for instance, with the thousands of windows we held--for example, curtains. We wanted some of those. We wanted covers for the back of the chairs. It seems it is a different manner of handling and entirely out of line with the original amount of money we received.

COL. THORNDIKE: Will you send a note on that up to Col. Schwichtenberg, $30,000 requisition for Fort Story Convalescent Hospital?

CAPT. BLAINE: While you are talking about $30,000, before Welch General Hospital was opened, a requisition was sent in for $30,000 for athletic equipment and other necessary items, and so forth. The answer never came back to us. It was sent directly on to Welch. We were waiting for the answer and finally in response to a follow-up note, we got the answer which was "No". In the meantime Welch was in dire need of athletic equipment and everything else. Col. Cook didn't have the money in his hospital fund to buy it. He had expended that.

Next, what about overseas—you say that overseas cases will be handled by general hospitals, and all cases in regional and station hospitals will be handled as a back-to-duty status. Now, about patients who have been overseas who break down while they are in the proximity of a regional or station hospital: what will be the disposition of those cases?

COL. THORNDIKE: You mean re-admissions?

CAPT. BLAINE: Re-admissions or men who have gone through a separation or classification center or redistribution center, and have been sent back to a unit for training.

COL. THORNDIKE: They are then a ZI unit, aren't they? They are then a ZI unit?

CAPT. BLAINE: They are then a ZI unit.

COL. THORNDIKE: Then they will go through the ZI chain of hospitals.

CAPT. BLAINE: The next is the question of the utilization of overseas personnel. I am sorry to say, we have had no real luck in the utilization of overseas personnel. They seem to want one or two things: either to get back with their unit or to get out of the Army. We have conscientiously tried to get these men into reconditioning. Occasionally we get a man and when we do we get a good one. We would appreciate it if the person who has been most successful in securing the services of overseas men would tell us how it can be done.

COL. THORNDIKE: I will defer that question until tomorrow when Captain Langhenry from our Personnel Division will bring down a new ASF directive, that simplifies the procedure of transfer of patients from a hospital directly into the detachment of that hospital without going through the laborious chain that now exists. It is in publication now and should be on your desk when you get back.

You raised the question of how one approaches the patient to persuade him to stay in the Army. Is there any one here from a general hospital or from a service command who has that problem solved?

COL. JENSEN: We were interested in this problem from the standpoint of the school, in maintaining personnel--we tried a little experimental run at Walter Reed. We sent an assistant personnel officer from the school, a Lt. Van Ostrand, and he spent five days at Walter Reed. He interviewed the men at Beltsville (Class 1 & 2) and at the Class 3 reconditioning center for Walter Reed General Hospital (Forest Glen), but not the patients in the Class 4 installation -- that is, the general hospital proper. In the five days he picked up 20 men. I think 18 of them have the Purple Heart, seven of them are officers and 13 are enlisted men. They voluntarily said they would like to stay in the Army, and indicated that they would like to do reconditioning. Their cards show very excellent qualifications. That is our one experience in picking at random an installation and sending an officer in who interviewed the men, explained the program and the problems of the program. He got 20 men.

MAJOR BOYNTON: 20 out of how many?

COL. JENSEN: 40 he interviewed. What he did was to get them together and present the program. This was just prior to the Christmas holiday season and many men were away.

MAJOR EASTMAN: We often are able to get voluntary participation by W. P. officers, but when we go to get the work out of them they disappear, you see, so it is a little hard to pin them down.

MAJOR GANSLOSER: We asked overseas officers to participate in our program and run our individual companies, and they wholeheartedly participate. Prior to our dispositions, we sent a letter through requesting that they be assigned to the hospital and all our requests to date have been refused, especially from those that belong to the ground forces.

COL. THORNDIKE: The new directive previously referred to by me will correct that. You will not have to go through so many channels.

CAPT. BLAINE: What happens if the hospital is up to authorized strength?

COL. THORNDIKE: I am not going to try to answer that. Ask Captain Langhenry when he comes tomorrow.

COL. BARTON: Major Lipton, you made a statement this morning to the effect that the manning tables presented were not authorized. Will you explain what authorization such a manning table carries.

MAJOR LIPTON: I believe that the military personnel must approve it. As far as I know, all tables of distribution or tables of organization are initially approved by ASF before the War Department releases it.

COL. BARTON: The table is a suggested guide only at this stage?

MAJOR LIPTON: Yes, sir.

COL. THORNDIKE: I think I might expand that. ASF personnel, as you know, will not release manning tables like this. This table was prepared in view of the fact that we have established a new type of medical installation. The table will serve as a guide to the specification serial numbers required to make a convalescent hospital operate. It is so new that a guide is believed necessary to requisition personnel on. We realize it probably will be changed before it is finally approved as the ideal table.

CAPT. BLAINE: What about requisitions that return to us regularly once every week and that reads at the bottom: "No such personnel is available"?

COL. THORNDIKE: Will you put all those questions up to Captain Langhenry when he gets here?

MAJOR PATRICK: I would like to ask a question about facilities. Would there be any objection to putting prefabricated or T. O. types of construction on hospital grounds for advanced Class 1 and 2 along with 3 and 4? We don't have enough convalescent hospital space so we are going to have to use some facilities that are adjacent to hospitals, in a few cases for Class 1 and 2, and I was wondering if you were going to stick to what Col. Schwichtenberg said rather liberally in moving clear out. What do you mean by clear out -- clear away from the hospital?

COL. THORNDIKE: I don't know. That is an Operations Service problem. I can't answer it for you and Col. Schwichtenberg has left.

COL. BARTON: At the present time Dr. Ginsberg, in charge of the Research Planning, has allotted 19,500 convalescent beds. He is holding in reserve 10,000 beds which he will distribute to the service commands that have the greatest need of them. He is doing that deliberately in order to put the beds where they are actually needed instead of distributing them now. As your own facilities fill up, he will allot the beds in the sector that has the greatest need.

MAJOR BRISCOE: Col. Thorndike, I gathered the impression from Colonel Schwichtenberg's discussion that he outlined the general plan by which we would meet our problems relative to returning wounded men from overseas, and relative to hospitalized patients in this country. I also gathered this impression: that he expected us to do the best possible job with the facilities we had and if it

meant using our judgment regarding some of these matters, in line with general policy, that we should do that. In other words, I should think if they haven't enough beds at Mitchell Convalescent Hospital, then, some plan would be devised to make use of vacant beds which would be as nearly in line with general policy as it is possible to remain. Am I correct in that?

COL. THORNDIKE: Your answer must come from the Operations Service, not Reconditioning.

COL. ALBUS: With reference to Col. Schwichtenberg's talk this morning, there is one question relative to a statement made by the Surgeon General to the effect that the patient-doctor relationship should be preserved. The impression conveyed this morning would be to remove general hospitals from convalescent hospitals.

COL. THORNDIKE: As recently as three weeks ago at the meeting of the service command surgeons in Washington, General Kirk again emphasized the doctor-patient relationship. That was before the speed-up of the patient evacuations had occurred

MAJOR PATRICK: A TWX is out on that, saying that the doctor-patient relationship shall continue. Is that going to be rescinded?

COL. THORNDIKE: It should continue even in a convalescent hospital.

MAJOR PATRICK: That leads to the point I was raising, that we were planning these facilities as annexes for the patient on whom final disposition would be made in a short period of time. That would mean Class 1 and 2 patients would stay on the general hospital area and not be transferred to a convalescent hospital. Yet this morning's talk suggested that would not be done.

COL. THORNDIKE: I can't answer that. I think you had better ask for clarification.

COL. GRABFIELD: In Boston not long ago we had a very distinct impression that there would be established a patient-doctor relationship between the staff and the patient to counteract the all too common tendency, especially in a military hospital, of considering patients en masse. We have made effort to establish in our convalescent hospital a patient-doctor relationship. In our command distances are short so that it can be done, but the important thing that we have tried to stress is to establish in the convalescent hospital the patient-doctor relationship.

COL. COOK: We interpreted that to mean to apply particularly to patients who are reconditioned for further hospital care in a general hospital, those patients to be returned to the hospital from which they came. I would like to emphasize the importance, in our experience, of visits by chiefs of service and representatives of the various specialties from general hospitals to our convalescent hospital. It assists us in adjusting our program. I have reason to believe that it has been of great assistance to the general hospital staff also.

COL. THORNDIKE: Col. Barton reported the AAF convalescent return to duty among N.P.'s as 80 to 90 per cent. I want to say that that is a very fine record. At the same time one must realize that the Air Force Convalescent Hospital received selected cases. While they are in the ASF chain of hospitals from overseas to that hospital, we weed out all the CDD's, almost all of them, before they go for convalescent care. I think that is a fair statement.

COL. BANTON: We will open this afternoon's program with "The Convalescent Training Section, its Mission and Organization", by Major Briscoe.

MAJOR BRISCOE: In order to discuss the mission of the Convalescent Training Section this afternoon, I would like you to refer to ASF Circular 419, 1944.

I think I can do no better than to read with you the Mission as stated in ASF Circular 419:

"The Mission of the Convalescent Training Section is to integrate the educational reconditioning, physical reconditioning, occupational therapy, and guidance and counselling functions of the Counselling and Classifications Department, to provide an organization of activities which are to be employed as specific treatment for general reconditioning under medical direction.

Specifically, the convalescent training section will offer activities designed first, to recondition patients who will qualify for return to military duty."

You will recall that Col. Schwichtenberg pointed out that that probably would be but a minor phase of the mission of the Convalescent Hospital.

"Second, to provide treatment in a non-hospital atmosphere for psychoneurotic patients and to offer try-out vocational guidance for aptitudes of such patients which may qualify them for assignment to useful military occupations."

And, three, "to provide counselling, exploratory vocational guidance and general information to aid in the successful adjustment to civilian living, restore self-confidence, and vocational usefulness of those patients whose disabilities are of such severity that they will be separated from the service."

And, fourth, "to promote fitness in surgical patients who are awaiting further operative treatment."

I should like to comment by saying that by integrating the services of educational reconditioning, physical reconditioning, occupational therapy, and guidance and classification, we mean that there will be programs so arranged in each of these fields that when taken together, they will constitute a sort of master program. Within that framework individual patients will be scheduled, according to their individual needs and individual interests. It should be emphasized that patients will be individually scheduled. Those for whom no suitable schedule can be arranged will remain in the receiving classes where a program adapted to their needs will be devised.

Chart 2 will serve as a guide for the organization of the convalescent training section. Notice it says: "will serve as a guide." That does not mean that you will follow this slavishly, but that you will follow it if you have no better plan. We think that perhaps it would be well, in the beginning, at any rate, for each of you, if you have not already established a plan of your own, to begin following the organization which is suggested.

The Case Board, which you will notice, shown in Chart 2, will be composed of the medical advisors, battalion commanding officer, assistant director for counselling and classification, chief of occupational therapy, assistant director for education, assistant director for physical education, and such other members from time to time as cases under consideration may require.

The Case Board will first advise on problem cases; second, review summaries of case records from time to time for the purpose of advising in respect to program and activities of the convalescent training section.

Departments of the convalescent training section consist of four, as you will note on the chart: physical reconditioning, counselling and classification, education and occupational therapy.

The functions of each department are as follows: Physical education to develop and administer a program of physical reconditioning for each class of

patients. Counselling and classification to study the records of individual patients, to interview them, give tests when necessary, and guide them in the selection of educational subjects, to program and to record the training progress of individual patients, to provide group guidance covering occupational information and vocational guidance. The education department will offer an educational program organized to provide the following sections: (1) while they are being counselled and guided in the inception of their individual programs, they will be in the receiving classes; (2) orientation and information sections; (3) military education, and academic education; (4) exploratory or vocational guidance experiences.

Occupational therapy will offer a treatment program which will provide, first, a therapeutic workshop furnished with the necessary mechanical equipment for treatment of physical disabilities. A workshop which will provide a wide range of activities for neuropsychiatric patients and finally a method for the progressive adjustment of patients in the convalescent training section.

The function of the convalescent training section fundamentally is to relieve the doctor of the responsibility for organizing and administering the program of essential convalescent activities, thus enabling him to give more personal attention to individual patients. When specifically prescribed for medical reasons such activities in which the patient may participate may become specific treatment for him. It should be kept in mind constantly that the program of instruction and of activities for patients is not to be thought of as a training program to be followed by every patient. It will be prescribed by the medical officers as so many hours of vocational guidance in a certain job family; the number of hours and whether in a sitting or standing position will be determined by the medical officer (see ASF Circular 419, 1944).

Emphasis must be upon the adjustment of patients through proper scheduling. Modifications of courses or scheduled activities to meet individual needs after selection or assignment by the patient himself, or by assignment will also be required. Such adjustments will be accomplished if the Case Board and the Classification and Counselling Department really work effectively.

Patients assigned to classes or activities who appear to be misassigned or who do not show sufficient interest in their classes or activities should be immediately referred to the Counselling and Classification Section. In case of neuropsychiatric patients, the psychiatrist should be consulted. Where problem cases cannot be solved by ordinary efforts at adjustment, reference should be made to the Case Board. And, of course, at all times these patients are under the direction of what would be the equivalent of the ward officer, their battalion commander, a medical officer.

I shall not indicate at this point the desired qualifications of personnel who will head these various departments and sections, except to emphasize one thing, and that is the director should be selected soon and he should be a man competent to fill the position which I have described in general terms.

Are there any questions at this point you would like to ask?

MAJOR PATRICK: I would like to raise one question. That Item under Counselling Qualification. I notice you have tests and measurements. I wonder what tests have been cleared with the Adjutant General's Department before you can give them to soldiers.

MAJOR BRISCOE: That will be discussed later by a representative from the Classific tion Section of The Adjutant General's Office.

There is a recent War Department circular on that point. I don't recall the number of it right now, but it will be referred to later.

I would like to take just a few minutes to state the mission in more realistic terms. Reconditioning is now in the public eye and may need some realistic appraisal as respects its mission.

Actually, the patient himself provides the mission of the convalescent hospital, and also of the convalescent training program. No program will succeed unless it pleases him.

Patients need treatment and opportunity to engage in activities which will facilitate their readjustment to civilian life, or to continued Army service. Some of these activities may run counter to the patient's desires.

Not only must you, who are engaged in reconditioning, accomplish your mission of giving the patient what he ought to have, but you must do it, if possible, so that he will be pleased about it all. You must do even more than this, you must satisfy the parents, the wives, sweethearts, uncles, aunts, and the public in general.

Suppose the patient doesn't want to do what is good for him. What will you do about it? You are also charged with the responsibility to the Army and to the nation to save as many men as possible for military service. Suppose the patient, though able to continue in service, doesn't want any further service? What will you do about that? Will you require the patient to do what is good for him or will you insist on the performance of his duty and run the risk of incurring his displeasure and perhaps public criticism? The answers to these questions are not as difficult as they may appear to be. First, one must begin with the patient himself. It must be recognized that he is a patient, that his bitterness, his apathy, or other symptoms of maladjustment, are rooted in his past experience. Patience will be required and gentleness, a cautious approach, and friendliness are necessary. An initial effort must be made to orient and to win him to the program. Pleasant surroundings, a fine mess, a minimum of restraint consistent with efficiency, evidence of personal consideration and friendliness on the part of the staff, will be the first step. Thorough explanation of the program and reasons behind it; its purpose and intent, will be the second step in orienting the patient.

A period of adjustment in which the patient is in a receiving class where, through personal conferences and group guidance, he will be led to consider his own needs and possible interests will be a third and preliminary step to his entering upon an individually scheduled program of reconditioning. Patients cannot be flung into classes like so many inanimate objects being classified, sorted and processed.

The growth of interest will lead to activity in the program. This can be stimulated through personal contact and through recognition on the part of the patient that there is something worthwhile in the program for him. The content of the courses must be of value so that they are not only interesting to the patient but so that he recognizes they do have some value for him personally. Subjects must be well taught.

Will there be occasions when it will be necessary for you to require patients to do something against their will? There will be such situations. But where attention has been given to orienting the patient properly, he will usually not resent such compulsion greatly and will often be glad of it later. It is difficult for anyone who is emotionally disturbed to stay consistently with a task or purpose. Most patients have suffered emotionally, whether or not such may be apparent. Sometimes it is good for a person to have someone insist that he complete what he has begun. One recalls many men following the last war who, for a long time, found it difficult to settle down to any job for long. They would have profited from firm guidance. When such compulsion is used, however, it should be employed as guidance and under competent professional advice.

No matter how good a program may be, if it fails of support, it cannot succeed. To achieve the mission of the convalescent hospital and of the convalescent training section, one must also be realistic about public relations. There must be a public relations program which begins with the patient.

The station hospital at Camp Crowder, Missouri, for instance, and other ASF hospitals, have caught the significance of this and are going out of their way to impress the patient and his relatives with the Army's concern for the patient's welfare. Christmas cards were sent out to all the families of the patients, for instance. Also, little messages from time to time. Such is not merely good public relations, it is also good therapy and mighty good orientation and education.

In summary, the following points are to be stressed in respect to the mission of the convalescent hospital:

1. The patient provides the mission.

2. The organization should serve his needs.

3. Programs are but devices which we use in the interests of individual patients and are not to be slavishly followed.

4. Good public relations are an essential aspect, and they begin with the patient.

COL. BARTON: The next topic on the agenda is a discussion of the relationships of ASF training to our present program. Major Cruze of the Special Training Branch, Training Division, ASF, will lead the discussion.

MAJOR CRUZE: Col. Barton, ladies and gentlemen, the first thing that I want to do is to bring you greetings from General Trudeau who is acting director, Military Training, Army Service Forces, while General Weible is on an assignment to the Secretary of War.

I am supposed to discuss in the next few minutes the relationship of the Offic of the Director of Military Training to this Convalescent Training Program.

Fundamentally, it is this: the Director of Military Training has responsibility for staff supervision of all training in the Army Service Forces, and his office is organized into divisions and branches to handle almost any type of training activity.

The Special Training Branch which I represent is a part of the Troop Training Division of the Office of the Director of Military Training. The Special Training Branch has been given the responsibility of staff supervision of advanced reconditioning training in ASF hospitals and of the convalescent training program in convalescent training program in convalescent hospitals of the Zone of Interior.

General Trudeau and his entire staff are aware of the urgency of this problem. As far as that is concerned, every staff division or every staff agency of the Army Service Forces, has been made aware of the urgency of this program. All divisions concerned have gone out of routine in an effort to cooperate with The Surgeon General in getting this program into operation at the earliest possible moment.

All of these staff divisions are willing and anxious to cooperate in every way possible, and certainly the Director of Military Training is anxious and willing to cooperate.

Last week a directive was sent to the commanding general of each numbered service command and the Military District of Washington concerning the operation of the convalescent training program. This directive contained three enclosures, all designed to aid in the development of this convalescent training program and to help the service commanders implement Circular 419.

Incidentally, this directive was sent out, directed to the attention of the Director of Military Training, the Director of Personnel and the Service Command Surgeon. In other words, it was felt that those three individuals in service command headquarters should get together and work out the details of this program within the service command.

The three enclosures that were sent out with this directive deal only with the convalescent training program. In other words, the Director of Military Training, ASF, has no responsibility as far as medical treatment is concerned, or as far as hospitalization is concerned, but only as far as the training program is concerned, he does have responsibility, and so his directives contain three enclosures dealing only with the convalescent training program. These three enclosures dealt with trainer personnel, equipment, and a program of instruction.

The first enclosure was a suggested table showing utilization of personnel for the training program -- training program only. This morning someone brought up the question of what is going to happen when you can't get this personnel. This directive tells the commanding general of each service command to utilize personnel

within the service command if it is available. If it is not available, then, he requisitions from the Adjutant General as usual and the very minute that a requisition for any one of these technical instructors, that are listed in this table of personnel, reaches the Adjutant General's Department, the Training Requirements Division in the Office of the Director of Military Training, will be notified. At that time that Division will go into action to make those technical instructors available from ASF training centers and ASF schools. In other words, we have them. We have these trained men, and if they are not available within the service commands, then we will go out to our schools and to our training centers, and make them available. You are not going to get the requisitions for these technical instructors back, marked "not available". They will be made available. The Director of Military Training has so directed his Training Requirements Division, and we are set up to go to work on that problem the very minute any requisition comes in.

The second enclosure is a tentative table of allowances. That will be discussed in detail a little bit later on, but it does provide the service commanders with authority to requisition from the Chiefs of Technical Services all equipment needed for this program that is not available within the service command. It is tentative, but it has the approval of the Distribution Division, ASF, and it has the approval of the Mobilization Division, ASF, and the Chiefs of Technical Services have been directed to fill requisitions based upon this tentative T/A.

Incidentally, a finally approved T/A will be made available shortly.

The third enclosure to this directive is a Detailed Program of Instructions (RTP 8-1) outlining the various courses that will be made available in vocational guidance to be offered in the convalescent training program. That, incidentally, will come in for more detailed discussion later on this afternoon.

This morning Col. Schwichtenberg emphasized the need to get the physiotherapy started. This afternoon I want to emphasize the need for getting this vocational guidance started.

Some of the service commands have already been visited by representatives of G-3. I think that I can assure you that other representatives of G-3 will pay visits to convalescent hospitals and other service commands in a very short time. Representatives of the Director of Military Training, ASF, will also be visiting hospitals. They will be looking for these training programs. That is the thing that they will be interested in. And it is imperative, and this directive to the service commander stated--"it is imperative that these programs be placed in operation at the very earliest moment possible". That is the directive that has come down from General Somervell's office. We are operating in accordance with that directive and we are trying to impress you with the need for getting this program into operation just as quickly as possible.

I want to assure you that you may expect the full support of the Director of Military Training, ASF, and of the Special Training Branch of that office, in all matters which pertain to training--the training aspects of this program.

If there is anything that you need along that line, we want to know about it, Col. Thorndike wants to know about it. Col. Thorndike will get in touch with us and I think that Col. Thorndike will assure you that we will cooperate; we are anxious to cooperate in every way that we possibly can.

Col. Thorndike asked me to tell you that we did go to General Staff and got a priority rating for this equipment of A-5-E. Convalescent hospitals will be included in the next list of priorities which is due to be published some time within the next week. It may be out, as far as I know. But that action has been taken. You have your priority established, and it will be in the next list of priorities which will be published.

MAJOR PATRICK: Would you mind citing that directive that went to the Directors of Military Training?

MAJOR CRUZE: The file number that went out from the Office of the Director of Military Training is SPTRP 353.9, and it was dated the 29th of December.

COL. BARTON: Thank you. We will next discuss the vocational guidance courses. Captain Dittrick will lead the discussion.

CAPT. DITTRICK: In considering the vocational guidance program, we must recognize that that is a phase of the educational reconditioning program as outlined in Circular 419.

I would like to consider a few of the basic principles of educational reconditioning as they apply to vocational guidance.

On page 1 of ASF Circular 419, at the bottom of the page, under "Basic Principles of Reconditioning", we will refer particularly to subparagraphs 4, 6, and 7. You will find that on the top of page 2.

Subparagraph 4, to quote: "Offer trial introductory training in the Army or explore capacities, skills, and aptitudes which may lead to successful rehabilitation and useful employment."

Subparagraph 6: "Educational reconditioning will offer training in military subjects to enable the individual to serve more effectively as a soldier."

Subparagraph 7 should also be considered. "Maintaining of liaison with public and civilian agencies charged with rehabilitation and the adjustment of the soldier to civilian living."

Further, in the advance copy of TM 8-290, which has been sent to all ASF hospitals and to service command headquarters. In Chapter 3, Section 3, page 9 refers to the phases of educational reconditioning. The philosophy and doctrine expressed in this section of Chapter 3 will apply equally to the convalescent and vocational guidance program, as it will to the program of reconditioning in general regional, and station hospitals.

It was early recognized from the kind of patients that were going to be assigned to the convalescent hospital that an expanded program of activities would have to be developed to meet particular needs. It was estimated that probably forty (40) per cent of the patients would be neuropsychiatric patients, another forty (40) per cent would be Class 3-A patients, or Class 2-B patients, and about twenty (20) per cent would probably be advanced reconditioning patients.

As was mentioned and emphasized by Col. Schwichtenberg, we all realize there is nothing static in reconditioning; it is ever changing. We recognize from the urgency of the situation that more hospital beds are required and from the figures that Col. Schwichtenberg gave us this morning, that our training requirements in each of these convalescent hospitals are probably going to be ever changing.

Major Briscoe pointed out that the program outlined in Circular 419 is intended as a guide. It will be necessary to make adaptations in terms of local situations. There must be flexibility in the program and in its application, based upon the careful evaluation and screening and classification of individual patients so that this program will be of therapeutic benefit.

It is not the intention to prolong hospitalization. The promotion of recovery and the attainment of the maximum benefits of hospitalization remains the primary objective.

It might be well for us at this time to analyze some of the charts. I would like to have you turn to Chart 5 in ASF Circular 419. Under the Educational Section of the Convalescent Training Section -- Educational Subsection -- we have various job families or various groups of activity. In the upper right, business education, electricity and radio, automotive mechanics, graphic arts, woodworking, agriculture, and at the lower extremity has been added metal working.

Beginning at the top, at the left-hand column. Orientation information, educational counselling, secondary and college courses, classes for slow learners, liaison with rehabilitation agency, and music.

As stated in the educational reconditioning manual, TM 8-290, it is pointed out that vocational rehabilitation is not considered to be the responsibility of

reconditioning in Army Service Force Hospitals. That, by public law, has been designated the Veterans Administration, but at the same time it is felt, particularly with the long-term hospitalized case, who obviously is going to be discharged from the Army, that there is a responsibility to give some purpose and direction to his convalescent days so that the whole process of vocational rehabilitation can be speeded up. There is a very definite need that there be effective articulation between the program we are attempting to develop and the programs that are being developed and have been developed by the Veterans Administration, United States Employment Service, and various state and local rehabilitation services.

The question of counselling has been covered in Major Briscoe's presentation and will be taken up in more detail tomorrow morning. We feel that in each of these eight job families or groups that there are certain skills that can be offered to the convalescent patient which is one basic to related civilian occupations as well as to the jobs that are required of an individual soldier.

After a period of instruction and placement in one of the courses listed, depending upon the previous experience, the interest and the aptitude of the individual patient, if he should qualify for return to military duty, he would move back to duty by way of a distributional reassignment center or possibly to an ASF training center for further training to qualify for a particular specification serial number or military occupation.

The great majority, are likely to return to civilian life. Then, as the arrows in the chart indicate, the patient would utilize the vocational guidance training to help secure placement in a related civilian occupation.

I emphasize again it will be necessary to make adaptations locally in terms of current and local needs.

I won't attempt to go through each one of the charts. They are set up on a similar pattern, covering the eight job families which are indicated in Chart 5.

I would like to bring out one point at this time, however: a discrepancy or an inconsistency that many of you may have noted, the 31 courses that are listed in RMP 8-1, do not conform entirely in nomenclature or name to the courses which are listed on these charts.

The purpose of this program, as stated on the second page, is to furnish a general guide for establishing and developing a comprehensive program of practical activities, to contribute to the mission of reconditioning based upon the doctrine set forth in the various training manuals for educational reconditioning, physical reconditioning, and occupational therapy.

Paragraph 3: "this program of instruction will integrate the services of the three branches of reconditioning". Paragraph Sub-C: "The program will provide a minimum of three hours daily of educational reconditioning activity. The instruction week may vary from 15 to 18 hours to conform to local requirements". In some installations it may be desirable to operate on a six-day program, other places five and a half, and others conceivably a five. Some latitude is given there to meet your local requirements.

Paragraph (1) refers to orientation.

Paragraph (2): "Two hours daily will be required in an educational activity. The courses offered will provide wide variety selected to serve the purposes and interests of large numbers of patients."

The program of technical shop opportunities may be supplemented by secondary and college courses provided through U. S. Armed Force Institute or by civilian education institutions where practical and desirable.

From the standpoint of establishing this training program, I believe paragraph d is important. "Admissions of patients will occur daily. Some will remain a a few weeks; others will spend months in a convalescent hospital before disposition is made. Educational background, civilian and Army experience of patients will very widely. The courses have been arranged in units of approximately 20 hours each, and sequentially arranged in order to provide opportunity for satisfactory assignment and to further enable the individual to successfully complete a chosen educational or training project."

Modification: "The following programs of instructions have been selected to offer technical and exploratory experiences in various fields involving skills valuable to the Army and basic to civilian pursuits as well."

Deletions or adaptations, of course, as outlined, may be made by the Director of Convalescent Training at respective hospitals with the approval of the commanding officer, service command headquarters, to meet the specific needs of the group of patients referred to in Paragraph 3-B above.

The doctrine and policies of existing WD manuals and subsequent ASF circulars and publications will govern all modifications. Whenever changes in courses are made a detailed program of instruction, including a statement of mission scope and references, and allotment of hours, will be forwarded to the Office of The Surgeon General."

On page 3 is a highly important point. Instructor guidance program: "Newly assigned officers, non-commissioned officers, and other instructors will be given an initial course of orientation which will emphasize instructional methods and understanding of the mission, scope, and nature of the program. Appropriate in-service instructor training will be conducted to develop a thorough understanding of and proficiency in the specialized nature of instruction demanded. This training may be in addition to the regular 8-hour training day."

Emphasis is laid on that paragraph for this reason: as Major Cruze has indicated, there will be training personnel available who are skilled technicians, who have a knowledge of the teaching methods and teaching standards that are required in Army schools. However, many of these men in all likelihood will not have had any contact with the convalescent patient, particularly the returned combat wounded soldier. We know from our experiences that the problem of instruction is different, the rate of absorption and the manner of acceleration must be adjusted to meet that specialized need. It will be necessary, therefore, in each local installation, to carry on an in-service training program so that the skill of these instructors can be directed to support the mission and the objectives of educational reconditioning.

It is hoped, that after the programs are established, it will be possible to bring the instructors who are obtained into Lexington, or bring them into a school where a course on reconditioning may be presented to them. They might be brought in on a rotation basis at a later time.

On page 3 of RTP 8-1 is a list of the courses which are covered in this program of instruction. The courses have been submitted by the various technical services in ASF. In some instances they appear to be the basic courses that are given in the training centers. In other instances special courses were developed in line with the needs as observed in a brochure which was submitted to them.

I have pointed out that was intended to be a vocational guidance or exploratory type of training. As you analyze these courses, you will find that there are some that go considerably beyond the exploratory or guidance phase. For instance, the course in "combination welding" contains some 440 hours of instruction. It is conceivable that there are going to be a great many of the patients who are interested in welding who are never going to complete 440 hours of instruction. It is also likely that there will be patients who have experience in welding, who will need to be placed at that particular level in the welding course where they are competent to begin.

You must consider the individual patient in each case and the program must be individualized and the instruction so developed.

I will not attempt at this time to go over each one of those courses. It would be better, I believe, in the discussion to follow, that you raise questions concerning any of the courses on which you may have some question.

COL. BARTON: Now, we will entertain your questions. They may be directed to any one of the last three speakers, Major Briscoe, Major Cruze, or Captain Dittrick.

MAJOR PATRICK: Mr. Chairman, these blessings are not totally unmixed, when

you set up 26 minutes to teach bearings in a training unit, and the inspectors come down from headquarters and start checking to see whether those trainees have learned their parts in 26 minutes, you take it out of the hands of a medical problem and put it on the basis of technical expert training.

I am wondering if there shouldn't be some kind of indoctrination of inspectors so they will understand that, after all, the patient is in a therapy program that cannot be measured in terms of criterion of achievement in 26 minutes or two hours.

MAJOR CRUZE: May I say something? I think that you will find that in so far as in respect to representatives of the Director of Military Training, ASF, are concerned, they are thoroughly oriented to that fact.

MAJOR PATRICK: I know some of my colleagues don't know a blooming thing about what we are trying to do. I have talked with them.

MAJOR CRUZE: Representatives from our office will visit these various convalescent hospitals, and after visiting will go by service command headquarters and will confer with the Director of Military Training there. For example, some time about the 18th of this month I expect to visit the hospital at Camp Lockett, and come by Fort Douglas, Service Command Headquarters and discuss the whole problem with the interested parties there. As I say, the representatives of the Director of Military Training have been working with Col. Thorndike on this program for several months now and we all recognize the fact that it is a medical program designed primarily for treatment, and as far as the inspectors from headquarters, ASF, are concerned, I can assure they will be thoroughly indoctrinated.

COL. THORNDIKE: I think that Major Cruze has put it correctly that ASF Military Training certainly understands that this is a medical program for patients. They also understand further that the patients flow, that they don't stay in the course until completion. When they attain the maximum benefit of hospitalization they are discharged. They aren't held to finish a course. It is not technical training in the literal sense, rather pre-technical training with vocational guidance.

COL. THORNDIKE: There is need for speed in getting the program established. There are certain hospitals that have been very imaginative and have already established programs along these lines ahead of the directive, and I can speak of Percy Jones. Their automotive shops are already operating. There is an urgent need to get this equipment, to get your personnel and get going, and you heard what ASF has said about their backing, there is no reason why, when any of you men go back, you shouldn't start the requisitions just piling in.

COL. STINE: I hate to raise the ugly question of funds again, but I notice that in these courses it is going to take a lot of expendable items. Where are the funds to buy these things coming from? Hospital funds would rapidly be drawn.

CAPT. DITTRICK: I think your answer will be given in the next hour.

COL. ALBUS: I would like to ask if the priority, A-5-E, is a civilian procurement priority or purely military.

MAJOR CRUZE: It may be used to obtain things from the Technical Services which you do not have available within the service command.

CAPT. BLAINE: Like the gentleman asking about funds, I hate to look a gift horse in the mouth and look at his teeth, but are you going to give us the bodies, or are you just saying you will train them? Are you going to set up a training school at Fort Belvoir and train the men that we send up there in a three weeks course or are you going to give us men who are already trained, have experience, and are teaching?

MAJOR CRUZE: This chart showing the suggested utilization of personnel for the convalescent training program in ASF Convalescent Training Hospitals went out to each service command. For example, it lists for a thousand-bed hospital two auto mechanics, 965. In other words, it lists the man, the course in which he will instruct, his "spec" serial number and the number which at headquarters we guessed would be necessary at a particular hospital with a thousand patients. Now,

then, what we will do as soon as you send in a requisition, is to pick up two 965's somewhere and ask the military personnel division ASF to order them to the Fourth Service Command. When you get them it is up to you to assign them to the particular hospital. However, any men you get by these requisitions, will be included in the bulk personnel authorization which you have in the Fourth Service Command. That authorization provides for a certain number of men to operate these convalescent hospitals. It provides for medical personnel as well as training personnel. In other words, each service command has a certain allotment of personnel. I think overall strength is being cut at the present time. The figure you have now includes the personnel necessary for the operation of this hospital. If you don't have men who are technically trained as instructors, then, we will see to it that you get them, but we cannot increase your personnel authorization over and above that which has been allotted to you by military personnel division, ASF. That authorization is supposed to provide enough authorized bodies to operate this program. We will see that you get the technically trained men. They will be trained in occupational specialties, and then I believe, as Captain Dittrick suggested, it may be possible to send them either here to Lexington or out to the ASFTC at Fort Lewis for orientation in the reconditioning program on a rotation basis. That isn't possible right now because these men have got to go to work and start this training program. Does that answer your question?

CAPT. BLAINE: Yes, but you raised another one. Namely, are you going to send say two men to a station, assume then the station is at full strength, must the commanding officer then dispose of two of his warehousemen or two of his men out of headquarters to make room within his authorization?

MAJOR CRUZE: That is exactly right.

COL. THORNDIKE: Col. Gould of MPD said he had telephoned to each service command personnel officer and established allotments for the convalescent hospitals. If you have personnel assigned that doesn't fit recommended serial numbers, you had better request ones that you will need, with the right serial number.

COL. GRABFIELD: As far as I know, the First Service Command did not get a new personnel authorization last Saturday. I mean our bulk allotment of personnel for the service command. At the same time we have had three new activities added, namely, the service centers and the convalescent hospital.

COL. THORNDIKE: I would suggest that we not take up the personnel matters until tomorrow when Captain Langhenry comes; you may raise that question again.

MAJOR SELINSKI: I should like to ask if it is expected that the N.P. patient, in whom I have a particular interest, will in six to eight weeks be expected to absorb sufficient knowledge and training that will enable him to obtain a new "spec" serial number, or does he continue his training elsewhere?

LT. COL. BARTON: I see in the question of Major Selenski a desire for information concerning the Developmental Training Units. You will recall that for a time the Army Service Forces operated at Belvoir, Lee, and Aberdeen, Developmental Training Units for N.P. patients. In August General Somervell turned over the function of the Developmental Training Units to the Reconditioning Consultants Division. It was believed that patients could receive equivalent training in the reconditioning program. As to the other part of your question, it is not intended to keep soldiers until they achieve a new "spec" number. If a man were to continue in the service long enough, then,he might incidentally acquire such a "spec" number but he is to kept only so long as it is felt that his individual case will benefit from the treatment program. If he has not completed his training and is to return to duty, he may go to a regular ASF training center and complete the course.

MAJOR CRUZE: I would like to add that the regular ASF training centers will be prepared to evaluate the training these men have received, and will place them in technical courses in accordance with their background. In other words, it may require only two more weeks of training after the man gets to the training center to enable him to qualify for a certain "spec" serial number, rather than a total of eight weeks in technical training.

MAJOR SENERCHIA: In regard to those last comments, that can only come

about with close liaison between the convalescent center and the reclassification or redistribution center. That isn't always possible. We have found it better to keep him up to 8 weeks until he has qualified in his new "spec" number, then he is returned to duty.

MAJOR CRUZE: That is all right only so long as you have the available beds.

CAPT. DITTRICK: Lt. Kisker, who is representing the Classification Branch, has helped plan the counselling and classification activities in a convalescent hospital. Could you comment on the role of the Classification Officer?

LT. KISKER: The personnel for the counselling and classification work indicated on your diagrams will be trained at the separation classification school at Fort Dix. That personnel may be requisitioned through service command headquarters. If the personnel is not available, at the service command level, that requisition will come on to us in the AGO where we have a substantial pool of men in each class who are available for assighment.

I should like to bring up one point, and that is the matter of terminology in ASF Circular 419. There are about five different phrases, such as counselling and guidance, classification and counselling, separation and guidance, which are mentioned, each slightly different; presumably all are the same activities, as it is to be the same unit. I am right in that, am I not?

CAPT. DITTRICK: That is right, yes.

MAJOR PATRICK: May I interject? I think there are two bases of counselling. One is counselling for the program, and one is separation counselling and guidance when a man leaves the service, and that, I believe, is what your field is--separation counselling.

LT. KISKER: It is more than that.

MAJOR PATRICK: You have added the other function?

LT. KISKER: It will be added under this plan. Up to now, it has been entirely separation classification, but with the convalescent program going into action, it will include much more than that. It will include the initial counselling, that is, programming. It will include a continuous type of counselling during the course of instruction in collaboration with the educational officers, the educational counsellor who is in most instances already available and then the separation counselling, whether that separation is back to duty or to civilian life.

MAJOR PATRICK: It won't be separation, it will be disposition.

LT. KISKER: It will be disposition. We will work out some terminology, but it is more than the separation program that you gentlemen have in your general hospitals at the moment.

Incidentally, I would like to call your attention to a circular that is just off the press a matter of a few hours. That is War Department Circular 486. It puts the activity of separation, classification, and counselling on the War Department level. We will be operating directly under G-1 in the matter of classification and counselling within hospitals of ASF and AAF as f r as that goes, but I suspect that most of you haven't seen that particular circular.

COL. BARTON: Before introducing the next speaker, I would like to give Col. Grabfield a chance to correct a statement which he feels may have been misinterpreted.

COL. GRABFIELD: I called the service command and spoke to the control officer. He told me we have received the allotment we asked for, for the convalescent hospital. It is materially less than the manning tables indicate. It is stated to be in accordance with agreement. It comes to a total personnel ratio of approximately .35. In other words, it is 525 for 1500 beds in the convalescent facility of a general hospital. That isn't adequate. It is under the figure of .4, which is, we were told by personnel, what we were going to get, and I want to correct what I said before, that we hadn't received it. We received it since I left. We got it on Monday.

We also were told: "Let's get these requisitions in as fast as possible because there is another cut in the offing and if the bodies aren't there we will have to take the cut from your fat, if the requisition isn't in." I pass that on for what it is worth.

COL. BARTON: The next item on our program is a symposium on equipment and supplies. I am going to ask Captain Dittrick to introduce the individual participants.

CAPT. DITTRICK: During the remainder of the afternoon's program, we are going to concern ourselves essentially with three areas: that of equipment, supply, and organization. We have representatives of the various technical services who will in turn, present that aspect of the subject with which he is familiar.

Capt. Allan of the Organization and Equipment Branch, Technical Division, Surgeon General's Office, will take up the subject of equipment, the manner of procurement, and necessary channels that should be followed.

CAPT. ALLAN: We in the Supply Service would like all of you to realize that the problem of funds, the problem of supplies and equipment, is very intricate. We must continually battle all kinds of competing organizations and installations, both within and without the War Department. In other words, we are in competition with the Navy, in competition with the Red Cross, and even within our own organization we are in competition with each other. That is one of the reasons why it is necessary for us to prepare such things as the equipment list which we distributed to you this morning.

I shall refer to the special instructions under Paragraph 4 on the third page of the tentative list. This is Med 10-24 and may be obtained from AGO Depots shortly after this Conference. It is the authority for obtaining supplies and equipment supplementing the other lists that are referred to in the instructions.

It says here: "Since convalescent hospitals are established on the premise that the bulk of patients will be housed in other than hospital buildings, housing, housekeeping, and messing facilities are to be furnished by the Quartermaster Corps on the same basis as provided in Tables of Allowance No. 20, equipment for posts, camps, and stations. Supplementary housing equipment not provided in T/A 20 will be requisitioned against Table 4 of this equipment list."

Convalescent hospitals are established usually at posts where barracks facilities and other facilities formerly occupied by troops are now to be utilized to provide housing for patients. The Quartermaster will continue to furnish all of the things that he had formerly furnished when the post was a regular active duty post. Initial medical department equipment for definitive treatment in a convalescent hospital will be obtained against medical department equipment list for a station hospital and hospital expansion units ZI of appropriate sizes, the size to be determined on the basis of 10 percent of authorized total patient strength.

Let us consider a convalescent hospital with a thousand authorized beds (drawing chart on blackboard). 10 percent of that, which will be in addition to that thousand beds, is for definitive treatment, and the equipment list for a hundred-bed hospital, therefore, would be the appropriate equipment list to provide the definitive treatment equipment for this hospital, plus the equipment that is authorized by Med 10-24, which has been divided up into receiving division, a reconditioning division, an infirmary, and then two additional tables in which supplemental furniture for dental clinics and some little linen has been provided.

Originally we were of the impression that a convalescent hospital would only be provided with the equipment that the Quartermaster would provide in the way of furniture and bedding. However, it now becomes evident that inasmuch as the men are still patients, we must provide additional linen other than that provided by T/A 20 which allows only pillow cases, mattresses, beds, and bath towels. The new allowances for linen may prove inadequate, but we have no way of determining as yet how much additional linen will be required.

Some of the equipment which has been provided in Table 1 may not seem very extensive. We are operating on the premise that a convalescent patient will not require any extensive definitive treatment, for that reason we have granted a limited amount of physiotherapy treatment and a very limited amount of diagnostic equipment.

In addition to the above, the Medical Department equipment listed in Table I of this equipment list is authorized to all convalescent hospitals, convalescent annexes, to General, Regional, and Station Hospitals and other authorized convalescent facilities and sections on the basis set forth in the list. That is the part that we must change after this morning's comments by Col. Schwichtenberg.

The items of Class 7, furniture listed in Table II, are authorized for day rooms and recreation areas in addition to those quantities authorized in the appropriate station hospital and hospital expansion equipment lists. Armchairs and costumers, davenports, lamps, and so forth, will be provided for any recreation hall or library in a convalescent hospital, on approximately the same basis they will be provided for in General Hospitals for regular patient use. "All requisitions for these items, however, must bear a statement as to the number of day rooms or recreational areas to be furnished and that available space for this purpose is adequate to accomodate the equipment requested." In other words, we didn't want people to order the furniture and then order a building to put it in, as has been done once or twice before.

The dental units appearing in Table III are for attached dental officers and are authorized in addition to any dental equipment issued as a part of the Station Hospital equipment under the instructions of 4-8 above. In those installations where the convalescent hospital also serves as a Station Hospital for troops stationed on the Post, supplies and equipment are authorized on the basis of bed capacity established in accordance with existing directives in addition to the quantities authorized in this equipment list. I think that provides for hospital beds at the rate of about three and a half percent of total strength.

The question of procuring funds, procuring non-standard equipment, and so forth, has come up two or three times in this meeting. You are all acquainted with War Dept. Circular 310 which restricted local procurement of standard or non-standard items, and also necessitated cancelling a number of allotments. The circular was prepared in order to protect the civilian economy and keep the various technical services from competing with themselves. I want to make it clear that that circular applies not only to appropriated funds, but also to unappropriated funds as well.

The responsibility for justifying a request for funds is entirely a local responsibility, and I think that it might be helpful to everyone if, in requesting funds, supplies, or equipment, you would put yourself at the other end of the line and ask yourself whether or not the justification you had given in your estimation is sufficiently clear, so that an intelligent consideration can be given of your particular request. We get all kinds of requisitions that must be returned automatically, because there is not enough information. You say, "We need so and so," but not what you have; you fail to say why you need it, or whether you have anybody to use it after you get it. Often a little more time at the station would save a lot of correspondence back and forth.

Other equipment lists also apply to a convalescent hospital. These are Med 10-25, physical reconditioning, and Med 10-23, which is an occupational therapy list, now being printed. It is quite extensive as compared to the last occupational therapy list.

If you have any recommendations as to additions to these lists, whether they be for occupational therapy, the convalescent hospital list, or physical reconditioning list, or any of the other lists that are involved in equipping your hospitals, the Technical Division of the Surgeon General's Office would like to receive your recommendations in order that proper action may be taken to either delete the items, add quantities, or make additions. The supply situation is now becoming so tight that equipment lists may shortly resemble overseas T/E's. What isn't on the equipment list isn't available.

CAPT. DITTRICK: Major Sandberg of the Supply Division of the Surgeon General's Office will now discuss supply problems.

MAJOR SANDBERG: As Captain Allan has told you, the Med Supply List 10-23 is for occupational therapy equipment and Med 10-25 is for physical reconditioning.

The physical reconditioning equipment is practically completely received in St. Louis Medical Depot.

During this month there should not be too many back orders on that equipment.

procurement for occupational therapy started some two or three months ago, before the list was even authorized. Up to 2 January there were only a couple of contracts incomplete. By the end of January over 90 percent of the items will be in the St. Louis Depot.

The Special Services Division has turned over a 4 to 6 production to the Medical Department for physical reconditioning and occupational therapy equipment and supplies. That turnover is sufficient to take care of our forecasted needs for a year.

Several inquiries concerning the expendability of physical reconditioning equipment have been received. Why are all physical reconditioning items listed as expendable? AR 35-6620 says that any physical reconditioning equipment such as balls, bats, tennis rackets, tennis nets, and other recreational equipment, will be made expendable, and that such equipment will be kept in a jacket file rather than a regular stock record account. That doesn't mean that a rowing machine can be taken home and red-lined off a jacket file. It does mean that you have to maintain property responsibility.

In other words, items are both expendable and non-expendable. In order to receive supplies and equipment for pre-technical sections, it should be sufficient to tell the Director of Supply that you want all the equipment that has been authorized by the new supply list, or for supplies that are authorized by the various "Four" (4) Sections of the Technical Services catalog. For example, Med 4 lists expendable medical supplies, Sig 4 the expendable Signal Corps supplies authorized, QM 4 for Quartermaster items, and so forth. It would be a good idea to avail yourselves of all these "Four" Sections of the ASF catalog series of the various technical services.

You will also want to avail yourselves of the T/A to know what equipment you will have. It is up to your Director of Supply to put a requisition on your local representative of the various technical services for the equipment and supplies that you are authorized. The question may be asked, "How are we going to get supplies that are not on the T/A or the equipment list, or not in the various section 4's of the Technical Services catalog? The only recourse is a non-standard requisition. If the S.G.O. believes the item of equipment or supplies should be put on all equipment lists, or the T/A, or the section 4's, they will add it and that will be authority for all other installations to get similar equipment and supplies. Your installation might be considered individually and authority granted for a non-standard item for your installation alone.

A list of available items of physical reconditioning will be published this month and will be forwarded through your distribution depot. The latter part of the month the list of available items of occupational therapy that are now available will also appear. In this way you will be guided in your requisitioning.

CAPT. DITTRICK: At this point I believe that it would be wise for me to take a few moments to give you the current information concerning the table of allowances prepared for use in the vocational guidance training program that was outlined a little earlier in the afternoon.

There will be many inadequacies in the allowances list, for example, there are included machine tools, certain types of vehicles for which the priority that has been assigned to this program will not be adequate. Also, in the list of ordnance equipment for the automotive course, there are a number of standard vehicles listed. These vehicles are critical items and cannot be drawn with an A-5-E priority. Consequently, non-standard vehicles must replace the standard ones listed. Again, with respect to lathes, grinders, milling machines, shapers, and items of that nature, the priority again is not high enough to justify issue of this equipment. The ordnance experts have not yet offered suggested solutions.

In some instances, the technical services in submitting their lists did not coordinate sufficiently within their own division between training and supply and equipment sections. Consequently the lists that were submitted were not wholly accurate. Secondly, some did not supply equipment lists to us which completely covered all areas with respect to the courses outlined in RTP-8-1.

A conference was held 2 January 1945, called by the Mobilization Branch, ASF, at which each of the technical services was represented. The T/A is in the process of revision. Each of the technical services is taking the program of instruction, the 31 courses, revising the equipment lists, as outlined in RTP-8-1. Revised lists have been promised by the end of this week.

I shall now cover the list of courses as given in RTP-8-1, and indicate the responsible technical service. In other words, this will indicate that the technical service is the source of the equipment to conduct that course. The equipment for these technical programs will not come through Medical Supply, but will be issued from the various supply depots maintained by technical services in question, as follows:

Course	Technical Service Responsible
Automotive Parts Clerk	Ordnance
Canvas and Leather Workers	Ordnance
Carburetor Specialists	Ordnance.
Carpentry	Engineers
Combination Welding	Ordnance
Electrician	Engineers
Engineering drafting	Engineers
Filing and correspondence	AGO with the Quartermaster supplying the items for it.
Lettering and sign writing	Engineers
Light Metal working	Ordnance
Machinist	Ordnance
Music	AGO function with Quartermaster issuing the equipment.
Office Machines	Quartermaster
Printing	Engineers
Pattern making	Engineers
Photography	Signal Corps
Power and light	Engineers
Printing and Reproduction	Some Quartermasters; others Engineers.
Electricity	Engineers
Radio	Signal Corps
Shorthand	Quartermasters
Telephone and telegraph	Signal Corps.
Tire rebuilding	Ordnance.
Topographic drafting	Engineers.
Typewriting	Quartermasters
Utility Repairmen	Engineers.
Watch repair	Ordnance
Wheel, vehicle, automotive mechanic	Ordnance
Woodworking mechines	Engineers

It is our feeling that the initial step must be to obtain a director of convalescent training and such personnel to assist him in order that an adequate survey of existing needs and layout can be made at once. There is no point, it is believed to begin to requisition equipment until you are sure you have the buildings or until the proper adaptation of buildings has been made to set up courses. A complete survey of existing facilities must be made and additional needs outlined.

In some installations you may not be ready to write requisitions until that survey has been made. By that time the complete and revised T/A will be published.

The next area that we are going to consider is the matter of visual education and visual aids. Mr. John Morrow who is consultant in the Reconditioning Consultant Division on the subject of visual education, will discuss that program with you.

MR. MORROW: Approximately two months ago the Chief of Staff, directed the service command visual aid coordinators to attend a conference in New York in reference to the distribution of films and other visual materials concerning demobilization and the post-hostilities educational program. Fortunately at that time the Surgeon General received an invitation to attend that conference to explain the need of the Reconditioning Programs in reference to production, procurement, distribution and utilization of equipment, films, and other types of visual aids.

The Chief Signal Officer and the Chief of the Army Pictorial Service, assured the Surgeon General at that time that there was no shortage of projection equipment and film materials within the commands to take care of the needs of the hospital programs.

After that conference some of the coordinators returned to their respective commands, picked up the ball, and did a very good job. Others failed to do anything about it. Unfortunately, at this time we have had no directive, or no basis upon which to establish film library facilities in each of the convalescent hospitals. This is why I would like to refer to the letter which you will find on the table,

dated 3 January 1945, which is being sent out by the Chief Signal Officer to all of the service commands directed to the attention of the Visual Aid Coordinators. The subject is "Film Services for Army Service Forces, Hospital Reconditioning Programs."

I will not read the letter in its entirety, but I want to point out one or two important things:

In paragraph 1, the Chief Signal Officer has referred to the basic convalescent training, RTP-8-1, and to ASF Circular 419.

In paragraph 1 (b) he directs that the Service Command Coordinators activate a film library of appropriate classification in each of the convalescent hospitals, and more important than that, in paragraph 1 (c) the service command coordinator visit the convalescent hospitals within the command to offer the following services; to establish a film library, to establish operator training, to inform the Director of Reconditioning and the Chiefs of the Reconditioning Services as to what films are available, both from War Department sources and from outside sources and to assist the Reconditioning Services in developing effective use of films, including their proper selection, preview by instructors, and effective introduction, presentation, and follow-up.

I would like to point out that Major Cruze from ASF Training, mentioned the cooperation that the Technical Services were willing to give to the convalescent hospital program. The last paragraph of this letter is a good indication of that, in which the Chief Signal Officer says: "It is contemplated that the Central Film Library of your Command will extend its services to the Reconditioning Program with the same vigor, imagination, and efficiency, it displayed in providing films, film library facilities, and advisory services in other training programs."

This shoudl be your basis, then, gentlemen, to establish adequate film library facilities in each of the convalescent hospitals within the Service Command.

The next thing I would like to refer to at this time is the program of instruction RTP-8-1: If you will turn to the course of instruction entitled Automotive Parts Clerk which is found on page 1 after the introduction, and the column headed "Text references and training aids," you will find related visual materials for specific units of instruction. The training film listed there is related to the unit on the clutch, the fuel exhaust, and so forth. Films, film strips, etc., have been incorporated into these units of instruction by the various technical services.

There is one change in reference to visual materials that I would like to point out, and that is Change 1, on the table. I think it is self-explanatory. Air Corps material, Navy materials, and commercial materials are not deposited in service command film libraries unless they are so authorized by either the Director of Military Training, ASF, or the Director of the Information and Education Division, ASF. We have received the necessary approval for the use of these visual materials. We have ordered them for you through the Army Pictorial Service and they will be deposited in your hospital film libraries in the near future.

I would now like to discuss the supply of visual materials from the Washington level to the service command level and to the actual post, camp, and station level within the command.

The function of procurement, production, and distribution of visual material, especially film material and other types of projected visual aids, is the responsibility of the Chief Signal Officer and his service command delegates. The Third Service Command has pioneered and has done a wonderful job in this respect. Your T/A calls for certain personnel for the visual aid department. You will be allotted a film coordinator, a visual aid development officer, and a certain number of enlisted personnel to do the job. In conjunction with that, you will have the services of the Service Command Coordinator for advice, counselling, and so forth. The Third Service Command has gone one step further: They have assigned a civilian coordinator at the service command level to work with the hospital programs within the command.

The supply of visual materials is through normal film library channels. Initial distribution of all authorized War Department films and film strips, and other types of film materials, comes directly from the Signal Corps photographic center to the film libraries at each of the installations within the command. If a new film is produced and is applicable to reconditioning programs, you will

receive an automatic distribution of the number of prints that will be required to meet your needs. The number of prints is determined by the director of reconditioning in cooperation with the Service Command Visual Aid Coordinator.

Approximately 90 days before distribution of new projected visual materials, a summary sheet is sent to the service command level with a complete description of the film material, outlining the type of aid it might be, telling the purpose, how it is to be used, and so forth. Therefore a representative of the interested agency at the service command level can sit down and tell the visual aid coordinator how many prints of that material he might need for his installations within the command.

All reorders of film materials will go through the visual coordinator at the hospital level, through channels to the Service Command Coordinator. Most of your reorders for film will be filled at the service command level because depot stocks are on hand. In very few instances will reorders have to go to New York before they are filled.

I was asked by Col. Thorndike to try to point out what the Educational Reconditioning Branch, and the Reconditioning Division, was attempting to do through the use of visual material. The chief of the Educational Reconditioning Branch has outlined the phases of educational reconditioning which you have in your manual TM 8-290. We are selecting, in cooperation with the technical services, other War Department agencies, and from outside sources film materials and other types of visual aids which will be helpful. When these film materials are selected and approved, a joint screening committee of the Army and Navy Board, will recommend the standardization, procurement and distribution of that material through normal film library channels.

I might point out two specific examples: You people know better than I do at this time, that too many of the War Department films are not applicable to meet your need. Therefore, we must go to outside sources to get other types of supplementary material. Materials chosen so far are March of Time films which can be used in orientation and discussion classes; and specific job information films, which have been tested and evaluated by the leading vocational men in the field. These will serve as part of your guidance and counselling.

I do not think that we will be qualified, at the Washington level, to try to meet all of the local needs of each of the hospitals. We will have to depend upon people at the convalescent hospital level, and other ASF hospitals, to tell us what your needs might be.

There is just one other phase that I would like to go into. A manual published by the Signal Corps called "Get 'em into Action" is available at the service command level which deals with film library operation, the supply, both initial distribution and reorder, of all visual materials.

CAPT. DITTRICK: The next presentation will relate to the large manning table that was distributed by Major Lipton this morning. At that time he asked that during the breaks and intermission you study that manning table so that questions concerning its application, could be brought up at this time.

Major Lipton will now consider your questions and attempt to explain it further.

MAJOR LIPTON: Manning tables are in no way mandatory. An attempt has been made to suggest an equivocal distribution of key personnel. It is only be experience and application of operational principles that more perfect distribution of personnel can be accomplished. With these facts in mind, your recommendations and comments are requested to enable us to perfect a table of distribution which will reflect your experience and eventually be recognized by the War Department on which necessary personnel can be assigned.

CAPT. DITTRICK: We are now ready for questions.

MAJOR BOYNTON: I would suggest that a provision be made for a medical officer (a specialist in physical medicine) conversant with physical and occupational therapy to be added to the manning table for convalescent hospitals.

MAJOR LIPTON: I don't know whether there is a specification for such an officer.

A VOICE: SSN 3180.

MAJOR LIPTON: I want to call your attention to the fact that 24 Medical Corps officers have been allotted in a thousand-bed hospital. If a specialist in physical medicine were added, he would have to replace one of the other officers.

MAJOR BEELMAN: I would like to inquire whether any provision has been made for short courses for medical officers who are interested in physical medicine with the idea of assigning them to convalescent facilities?

CAPT. GRACIE: No such course exists at the present time. There are a number of courses in preparation at present but none of them are ready for announcement. The majority are designed as refresher training courses, for officers who have been away from professional duties for some time.

COL. STINE: It occures to me that in a convalescent hospital of a thousand beds, there might be approximately 80 percent orthopedic patients. I don't believe that one orthopedist would be able to anywhere near cover the ground.

MAJOR LIPTON: You may assign more specialists in orthopedics by dropping an equivalent number of other medical officers to meet your unusual patient distribution.

COL. THORNDIKE: I think that hospitals will vary in the type of cases they have. Some may have a number of orthopedic cases in their convalescent section that will require more "orthopods"; others will have neurosurgical cases. I think the individual hospital will have to judge what it needs in the line of specialists and judge accordingly. From period to period it might change.

CAPT. HALL: Is there no provision made for a civilian librarian?

CAPT. DITTRICK: That has been considered. I think there have been some personnel indicated under Special Service personnel. Civilians may replace military personnel in accordance with the War Department policy wherever possible.

CAPT. HALL: There is a provision in AR 210-70 for allotment of a librarian to any hospital with over a thousand beds, and it seems to me that one should be provided whether or not there is a service club.

CAPT. DITTRICK: I believe Special Service has a provision for personnel to carry out the functions of a library.

MAJOR LIPTON: We can make the suggested readjustments to provide a librarian. Will one be enough for one thousand beds?

CAPT HALL: According to AR 210-70 a civilian librarian is authorized for every hospital with a thousand beds.

COL. CUTLER: In the abstract of Col. Barton's talk this morning this sentence is found: "In respect to personnel, it should be emphasized that there is urgent need to secure immediately two thoroughly qualified officers, one to handle the reconditioning division and one to be director of the convalescent training program.

Will you be good enough, Col. Thorndike, to outline the qualifications for those two men?

COL. THORNDIKE: That is coming up tomorrow with personnel matters. I think we will defer it.

CAPT. LILLY: It would seem logical in view of the trend to move class 3 patients in convalescent hospitals, to provide a better student instructor ratio in relation to 283.5. More than one physical reconditioning instructor is needed per 100 patients; it should be 2 or 3 per hundred.

CAPT. DITTRICK: Utilization of personnel is optional with local command; 535 enlisted personnel in relation to the thousand-bed hospital is tops as far as that is concerned. Adjustment would need to be made within that limit.

MAJOR ESSLINGER: The same basis was used to provide physical reconditioning instructors as in ASF Circular 73. If you remember, it provided one "283" per 100 patients for Classes 2 and 3. I think that is adequate to handle the job of physical reconditioning. I think what Captain Lilly has felt is that there are a great many more duties in the administration of that company which are developing. Perhaps it is not so much another "283" that is needed as another NCO for general administration. I think one "283" is certainly adequate to handle 100 men for two hours and a half a day, which is the full load that he carries.

MAJOR LIPTON: On the assumption that a thousand-bed hospital will receive 500 patients a month, approximately 20 patients a day will be received for 30 days. In the receiving division 14 duty soldiers have been allotted to take care of baggage and assist newly arrived patients to their quarters; to receive approximately 20 patients a day would give each man about one and a fraction patients to take care of.

If the recommendation would be accepted by the Surgeon General's Office, Hospital Division, we could replace some of those men with more appropriate personnel.

MAJOR ESSLINGER: I would like to raise a question. I have been increasingly concerned as to whether or not the physical reconditioning officers who are serving as company commanders are so overwhelmed with company administration that they are not able to serve in the capacity for which they are especially trained. I think it would be very unfortunate if that were true and I would like to have an expression of opinion from Major Morgan and Major Webster and some others.

MAJOR MORGAN: We have found that to be exactly the case. Where a man is saddled with company responsibilities, he is unable to carry out the physical reconditioning program as it should be carried out.

MAJOR WEBSTER: Our difficulties haven't been quite so great. The CO's in most of our companies have been patient officers and they have gotten along nicely within our organization, although we felt that perhaps we could get better results if we did have a PR officer as the CO of the company. On the other hand, if he is saddled with too much of the organization of the company, he may not be able to give sufficient time to the physical reconditioning. We have thought it wise to have the PR officer as the CO for the company, with a patient officer as the executive officer of the company. We haven't tried that, but we are considering it.

MAJOR EASTMAN: I don't know whether I have seen correctly or not, but I see fireman listed here, "084", with an allotment of two. If that is all, I would like to know how two firemen are going to fire in two areas two miles apart, a total of possibly 50 buildings, each one of them having as many of three or four fires in it. How are they going to do that?

Also, I don't see how the number of medical officers allotted is adequate. There may be 600 patients in a battalion, or possibly more--and a lot of these patients, Class 3-A's, needing physio-therapy. How are the officers going to check X-rays and see that these men are properly cared for and make the necessary progress notes and see that they get back to the right kind of duty at the right time and as quickly as they can?

MAJOR LIPTON: The two firemen allowed are for laundry purposes, not to put out fires. Is that what your question was?

MAJOR EASTMAN: I mean to build fires.

COL. JENSEN: The patients have to keep their own stoves going.

MAJOR LIPTON: These are for the laundry facilities only.

CAPT. DITTRICK: The time is drawing a little short, and we have not yet taken up questions of supply.

MAJOR EASTMAN: I would like to bring up a question relative to physiotherapy equipment. For 2000 patients, two leg baths--whirlpools--are provided. We have heard an estimate that up to 80 percent of orthopedic cases are to be expected. Those patients are going to need a whole lot more similar equipment.

CAPT. ALLAN: That is just exactly what we would like to know. In a 2000-bed hospital, how many do you think you would need?

MAJOR EASTMAN: This looks to me like it ought to be multiplied by 10 in every one of these categories for physiotherapy.

MAJOR BOYNTON: What about cannibalization on hospitals that are being closed?

CAPT. ALLAN: Where they are being closed, they are being used.

MAJOR BOYNTON: You will want to increase the hydrotherapy equipment. I will give you a breakdown on it later.

CAPT. ROBBINS: Are any regulations existant that prevent the receiving of occupational therapy equipment in kind or supplies that you know of?

CAPT. ALLAN: No. We are perfectly willing and happy to have civilians contribute anything that they want. The trouble in the past has been that they contributed it all to one place. One hospital got all kinds of leather, others did without. If there is any large quantity of available materials it should be reported to our office so we can make distribution.

CAPT. ROBBINS: Would that apply to equipment also?

CAPT. ALLAN: That would apply to anything of that nature. There is one thing I didn't bring up before, and that is items of critical equipment such as typewriters. We have a limited number of typewriters on the list. That is all you are going to get. We had to fight to get those. ASF warned that if typewriters or office equipment of that nature was diverted from the convalescent rehabilitation program to administration or something else it would be taken away from the installation. If you get typewriters that are intended for instruction purposes and use them in administrative offices, an ASF inspector is probably going to take them up if he finds them.

COL. THORNDIKE: The same applies to printing presses.

CAPT. ALLAN: That is right. Printing presses, adding machines, or anything that is of a critical nature.

COL. CUTLER: I would like to point out, in reference to the need for large numbers of whirlpool baths, that it is a very easy matter to prescribe manipulative physiotherapy, especially in our convalescent hospitals, often to the disadvantage of the patient. He may easily become lost in the manipulated physiotherapy, and fail to benefit by the directed active individual exercising of the disabled parts that may be required. I would say just a word of caution in regard to the matter of equipping our convalescent hospitals with large numbers of diathermy, whirlpool baths, and the rest of it, simply because it becomes so easy to catalog the patient as receiving physiotherapy and oftentimes injudiciously and not economically. I recommend prescribed individual directed active exercise as opposed to manipulative physiotherapy.

MAJOR BOYNTON: That was why I suggested the need for 3180 (Physical Medicine Specialist).

MAJOR BRISCOE: I would like to ask if Major Sandberg didn't also mean to include ASF catalog "5" as well as "4". It is a list of items carried in stock at the various depots in the service command.

MAJOR SANDBERG: That is right. That will help to get items that don't appear on the T/A or in the Sig 4, Med 4, QM 4. If you get the Sig 5, QM 5, and so forth, which is the stock list of all items, that may also help you find other items that are available that people in Washington haven't thought of including in the program. In the medical catalog series, we don't have a Med 5--our Med 3 includes what would normally be our Med 5. You will find there, probably in our "F" class (our occupational therapy class), many items that you can use in voca-

tional guidance courses.

MAJOR CRUZE: I would like to add one word about the tentative T/A. As Captain Allan pointed out, the permanent T/A will be published very shortly. However, within the service command you will know what equipment you have. You will have a pretty good idea of what equipment you are going to require. You also know how long it takes to get equipment after requisitions have been submitted.

This table of allowances is authority for requisitioning equipment from the chiefs of technical services that you do not have within the service commands so those requisitions will be honored. Equipment that you do not need, you may turn in.

I would suggest that you do not delay too long about preparing the requisitions for the items that you know that you are going to need. There will be unavoidable delay in the distribution of the final T/A. If you wait to prepare your requisitions before submitting them, the first thing you know, it is going to be two months before you have anything. So don't get caught short.

COL. BREWER: We were told not to requisition until we had buildings to put them in a short time ago. Now we are told to prepare the requisitions immediatel and send them in. I would like to interject this thought that our engineers are ready to go to work preparing our class rooms and things of that kind. They say they cannot prepare these rooms until they know what is going in them and we have been unable to find out what is going in them.

CAPT. DITTRICK: In connection with the Third Service Command problem, several officers, including the Service Command Engineer, were in Washington last week. I believe at that time, Major Boynton, we agreed upon the design and requirement for some eight or nine buildings, and have made arrangements to go to Aberdeen immediately at the conclusion of this conference to get the other buildings laid out in the proper manner to contain the equipment that will be used.

MAJOR BRISCOE: I was going to comment on your statement earlier in reference to what you spoke of. I don't think, Captain Dittrick meant that you should wait until you had a complete layout of every building and a complete survey, but that as soon as you knew--for instance, if you had one shop that you knew what equipment was to go in there, you would order for that.

CAPT. DITTRICK: That is right, Major. I am sorry I gave any different impression.

We may find that in a convalescent hospital in the Middle West there may be a greater interest in machine tool work, welding and metal trades. We may find that in the southern part of the country there is more interest in textiles or agriculture. Interest may vary from one part of the country to another. Revise your requirements accordingly. That is what I referred to when I said that you must make an adequate survey of your needs. Some have already made such.

MR. MORROW: I would like to point out one thing I think I failed to do. The projection equipment and film library equipment is not included in the proposed T/A's that are before you. You will draw your projection equipment and film library equipment against existing T/A 20-2 which has already been approved and authorized, according to the classification of film library.

PROCEEDINGS OF THE CONFERENCE

January 4, 1945.

Morning Session.

COL. THORNDIKE: Will the conference come to order please. I will appoint Major Gwynn as moderator for the morning.

MAJOR GWYNN: The morning program will open with a paper by Major Esslinger, who is Chief of the Physical Reconditioning Branch, on

"The Physical Reconditioning Program in Convalescent Hospitals".

MAJOR ESSLINGER: The Physical Reconditioning Program in any hospital must be based upon the needs of the patients in that hospital. It has been anticipated that patients in Convalescent Hospitals will be divided into the following categories:

20% Advanced Reconditioning.
40% Neuropsychiatric.
40% Primary Reconditioning.

It is obvious that the nature and purpose of the Physical Reconditioning Program will vary for these various groups. The program for each will be discussed in turn.

Since the patients in the Advanced Reconditioning group are to be returned to duty they will follow the program outlined in ASF Circular 217. The emphasis will be upon the development of maximum physical and mental fitness in these patients before they are returned to duty. This requires a combination of tough rugged physical activities such as calisthenics, guerrillas, grass drills, log exercises, marching and running, combined with relays, combative events and competitive sports.

The Physical Reconditioning Program has an important role in the reconditioning of neuropsychiatric patients. These patients are of two general types. One group of patients have symptoms which are so severe that only light activity can be undertaken and that only under careful supervision. The activities must not appear to be too strenuous to them. The best activities for this group include horseshoes, croquet, table tennis, archery, shuffleboard, golf putting and the like.

The group which manifests attitude reactions is able to participate in strenuous activities once they are motivated to do so. Part of this group is very cooperative and will readily engage in physical activities. The remainder of this group is critical and complaining and will require considerable persuasion. However once they have entered into an activity they will participate vigorously.

For the group of neuropsychiatric patients who can participate in vigorous activities the Physical Reconditioning Program seeks to develop a high level of physical fitness. If this objective can be achieved it cannot help but prove beneficial to them, providing, of course, that the proper approach is employed. The lack of strength and stamina which leads to fatigue and exhaustion may frequently be a factor contributing to the neuropsychiatric condition. If they are well conditioned, the feeling of personal fitness and physical well-being will aid their readjustment whether they are discharged to duty or to civilian life.

Another objective of the Physical Reconditioning Program is to provide activities which are enjoyable and satisfying to neuropsychiatric patients and which will provide them with an opportunity for self expression and release from tension. With proper leadership and guidance this participation can be a successful experience and can lead to the development of a sense of belonging, and of worthwhileness.

While the objective for neuropsychiatric patients do not differ essentially from those of the patients who are to be returned to duty, the activities and

methods by which they are attained are quite different. The activities must be interesting and appealing to the patients and every effort must be made to motivate their participation. The program should stress sports and games and should include only a minimum of regimented, formal activities such as calisthenics. Under the excitement of competitive athletics patients forget their aches and pains. Eventually the patient realizes without his being told so, or his attention called to the fact, that his disability no longer troubles him so greatly.

Team sports are especially valuable for this type of patient. It has been increasingly recognized that active participation in group activities, particularly where a strong feeling of "belonging" to the group is involved, is often conducive to the emotional well-being of the individual of that group. It is desirable that the groups be fairly equally matched and measures be taken to prevent a team from losing constantly.

Neuropsychiatric patients should be treated in the same normal manner as medical or surgical patients. They should not be considered as "peculiar" or "queer." They respond best to individuals who are genuinely interested in them. They should be required to attend formations but they should not be regimented in their physical activities.

The patients in the Primary Reconditioning Section have long term orthopedic, surgical and medical disabilities. The initial emphasis of the Physical Reconditioning Program for these patients should be upon the fullest possible recovery of weakened and disabled tissues by means of carefully prescribed remedial exercises and reconditioning activities. These exercises and activities will be administered as prescribed by appropriate medical authority by physical reconditioning personnel in coordination with the Orthopedic Service.

Despite the fact that practically all these patients will be C.D.D.'d it is very important that they develop a high level of physical fitness consistent with their capacities. These men will return home physically handicapped and the possession of a moderate amount of strength and stamina will prove an invaluable asset in meeting the problems associated with readjustment to civilian life. Since these patients will remain in the hospital for a considerable length of time, ample opportunity to condition them adequately will be available.

A very important objective of the physical reconditioning program for patients in Primary Reconditioning is to provide recreational and competitive sports. A well-organized and administered sports program can contribute as much to these patients mentally and emotionally as well as physically. The deep satisfaction, the sense of accomplishment and the feeling of pride and elation in a well hit drive or a perfect approach, in a bulls-eye, strike or ringer, or in an accurate placement or a smash, in a kill-shot -- all these constitute good therapy.

The maintenance of a high level of physical fitness is so important for these patients that a strong effort should be made to provide them with activities with which they can maintain their condition in civilian life. Every patient who is being discharged from the service should be taught a simple set of setting up exercises which he can employ at home. Some may prefer barbells or dumbbells. In addition, physical recreational activities which meet the needs and interests of these patients should be provided. Recreational sport skills should be taught to the permanently disabled which will permit sports participation during post-convalescent years.

It is obvious that with $2\frac{1}{2}$ hours scheduled daily for the physical reconditioning program that all of this time cannot be spent in strenuous activities. Most of the patients will not be able to participate intensively for more than 40 to 50 minutes. The remainder of the time may be devoted to light recreational sports, to sports instruction and to intra-group competition.

It is strongly recommended that emphasis be placed upon teaching patients the fundamental skills and techniques of different sports. Many men are not interested in badminton, tennis, bowling, archery, golf, handball, swimming, volleyball, horseshoes and many other sports simply because they have never learned them. Many of the orthopedic and surgical patients will be permanently disabled and will not be able to participate in sports which formerly provided them pleasure and satisfaction. These men will need to be taught new recreative activities which are within their capacity. One of the most significant contribu-

tions of the Reconditioning Program in the Convalescent Hospital would be to provide the patients with new and satisfying resources for their leisure hours.

Another way to make the Reconditioning Program more successful is to organize athletic competition into tournaments and meets. There is a vast difference between an informal volleyball game and one in which the teams are competing in a league. The entire athletic program will be stimulated and the contestants will obtain much more pleasure and benefit if the teams and players are playing for a purpose.

MAJOR GWYNN: I think our program of Army Service Force hospitals that has been criticized in some quarters as having been regimented; and one reason is the compulsory calisthenics that we see in the general and regional hospitals.

I think Major Esslinger can tell us of some ways of making those calisthenics as attractive as possible.

MAJOR ESSLINGER: I am glad you raised that question, Major Gwynn. There are not very many people who like to do calisthenics. Leaders here and there have been so skilled as to make calisthenics attractive for the participants. Such leadership is rare. Calisthenics do have an advantage, however, for when an exercise is well developed it reaches and exercises and develops all the important muscle groups of the body. It can be used anywhere. It doesn't cost you anything, so it is a desirable activity to maintain provided, of course, the men can be motivated to participate. In the second place, I would say to use the cumulative count. By that we mean -- when we count push ups we are counting in cadence; "Hut, two three, one; Hut, two three, two" etc., and you have a set standard.

MAJOR GWYNN: The next paper of this morning's session will be given by Major Briscoe, Chief of the Educational Reconditioning Branch.

"Educational Reconditioning Program in Convalescent Hospitals".

MAJOR BRISCOE: I think it might be well if you would turn to the charts in ASF Circular 419, to the flow chart which is Chart No. 4. When a patient comes into the hospital he comes into the Receiving Section where he is medically processed. It is determined whether or not he will go into the Reconditioning Division or not. If he is graded into the Reconditioning Division, he will be assigned either to the Neuropsychiatric Reconditioning Section or to the Primary or to the Advanced Reconditioning Sections.

In line with what Colonel Schwichtenberg said yesterday, it would appear that most of your patients would be in the Primary Reconditioning Section, particularly if you get any appreciable number of 3-A patients.

Simultaneously with the assignment of patients they should be entered into the receiving classes of the Convalescent Training Section. The receiving class is a sort of an adjustment class or classes similar to those commonly found in highschools, where students who cannot get along in the regular program, are carried as a group. There will also be the classification and guidance department which Lieutenant Kisker will explain.

Patients go from the receiving classes into the Neuropsychiatric Section or into Classes 3 and 2 where they receive orientation, current problems, academic education, exploratory shop classes, occupational therapy, hobbies, diversionary activities, and so forth, or into Class 1, where, I may remind you again, there probably will be few patients. From there they may go back again after the completion of their work, to the Counseling and Classification Section, then to the Disposition Board, and from the Disposition Board, or when it is known what is going to happen to them, they will be referred to the various civilian organizations such as the Veterans -- or Governmental Adjustment organizations, such as the Veteran's Administration, Red Cross, United States Civil Service, Personal Affairs Officer, or to the local and state rehabilitation services.

It was the opinion of The Surgeon General's Office that neuropsychiatric patients should be segregated from other patients in the convalescent hospital.

I have no personal opinion on that. That may be a matter that you physicians will want to discuss. I should like to point out, however, that the classes that

we have described yesterday are not meant to be training classes where a man necessarily starts at the beginning and comes out with a "Spec." serial number.

As we said yesterday, in this classification a hypothesis will be made as to what the man's residual capacities are, what he may still be able to do. The training in the classes will be a sort of performance tryout of that hypothesis to see whether or not the paper and pencil and interview results will really stand up.

It is not for the purpose of training the man to become an auto mechanic, but rather to explore his interests, his capacities, his ability for work, to discover whether or not it might be profitable, to encourage him to go on to become an auto mechanic in civilian life, or whether it would be worth while to assign him to a retraining center for training in the Army, if he be going back to the Army, that these classes were designed.

We have discovered that people learn with their whole being. They don't learn just with their minds. They learn with their emotions. Even their physiological reactions within themselves affect their learning. For instance, it makes a lot of a difference what kind of a breakfast a child had in the morning before he comes to school, as to whether or not he can learn his arithmetic. It makes a lot of difference what state of mind he is in, whether there has been a quarrel, whether he got up late, whether his mother was cross and scolded him before he came to school. All of those things count. Therefore, it must be emphasized that the education program is but a small part of the thing you are doing and fits into its proper place. Very often too much, far too much, is expected of education.

The American people are education minded, and they seem to think that education is the answer to everything. Well, it isn't. It seems perhaps a bit unseemly for me as an educator to say that, but I must put that warning to you in the beginning. Because you have classes, because you have somebody looking after orientation, it does not follow at all that the morale of your camp or your post is going to be high.

Morale is dependent upon other things. It is dependent upon the personal interest and the friendly attitude that is taken toward the patient. It is dependent upon the kind of recreation program that you have, the kind of mess you have, and on similar things. Many people seem to feel also that about all they will have to do in respect to the education program is to offer something that is worthwhile and good, and that from that point on all that will be necessary will be to post a guard at the door to keep patients from crushing each other as they rush in eagerly to take courses. That won't be true at all, as you well know.

People generally aren't very much interested in improving themselves. People are interested in goals which they recognize as important, and adults particularly are not docile. It is harded by far to teach them than it is to teach small children. I never saw a first grade child who wasn't interested in learning when he first came to school, but I have never seen a highschool class, nor a college class, nor even a graduate class in college that wouldn't be pleased if the professor failed to show up so that they could cut after the ten minute waiting period. We lost our interests.

Therefore, the program that we have put forth must be charged with interest from the beginning. It should have something of personal value also that the individual can see. One of the things that makes most of us work hard is that if we didn't work we wouldn't eat. So vocational motives are very strong ones, and they should be stressed.

There are also things that are naturally interesting to men which, if presented in interesting ways will hold them. Newsreel theaters in this country have developed a new technique in education. If one could conceive of the Newsreel Theater as being directed toward certain educational ends, he would in a sense conceive a great national university. The visual education program which the education officer advises, if he can get the right films, -- that is films that will be educational and at the same time interesting -- will provide a suitable educational method. You have to "catch them before you can learn them," as the teacher once said.

I would like to mention one thing that you may have found on your desks this morning. The pamphlet developed at Cushing General Hospital. If the man's personal problems are first met and taken care of as soon as he enters the hospital, you have established that personal rapport which is the necessary beginning of all good education.

At this point, I would like Captain Dittrick to carry on more specifically in reference to the classes proposed.

CAPT. DITTRICK: With respect to the educational reconditioning program, we have the cart somewhat before the horse this morning, because of the change in program yesterday. Supplementing a bit what Major Briscoe has said, it is my personal opinion that the only justification of any educational or training activity within reconditioning is the degree to which psychological reconditioning is accomplished. No educational activity should be included in your program that fails to contribute to improved attitudes, or to maintain that high degree of morale among the patients.

In Circular 419, paragraph 2, pages 1 and 2, yesterday I referred to four of the basic principles of educational reconditioning. I would like to point to the others of the seven listed. No. 1 on page 1, "educational reconditioning will stimulate interest in the progress of the war and problems of the peace." That, of course, relates to the orientation mission of educational reconditioning. You will recall that in Circular 419, three hours is designated for educational activities, two hours of which was described yesterday as relating to the vocational guidance program. One hour daily is for orientation and general information on all type of work.

Point one, which relates to the orientation mission will require a considerable amount of study and adaptation with respect to the types of patients being reached in the convalescent program. The basic orientation program which has been developed by the Information and Education Division is not satisfactory for patients who have returned from combat and who are likely to return to civilian life.

With the advanced reconditioning group, the 1's and 2's who are going to return to duty, a certain portion of the basic orientation program can be used with good effect.

T.B. Med 80, outlines general principles with respect to orientation for the neuropsychiatric patients. There is no established program as yet for those who are returning to civilian life. I and E Division has been working on such a program. We expect within a short time to have a T.B. Med published with respect to the orientation program for this phase of educational reconditioning.

Sub paragraph 2 states "To redirect the soldier's thoughts from the narrow concept of himself, to a realistic appreciation of his responsibility as a citizen of his community, state and nation." That, of course relates to those who are likely to return to civilian life.

Point 3 "Provide individual counselling service to discover interests, capacities and aptitudes as a basis for further training or education." Lieutenant Kisker, I believe, will cover that in a few minutes.

Point 5. "Provide opportunities for general education which will enable individual soldiers to continue educational pursuits interrupted by induction into the Armed Forces." With respect to that point, I would like to refer again to Training Manual 8-290. In Chapter 3, I would like to quote from paragraph 15:

"Education is most effective when it builds upon the experience learned. The richer the background of experience, the greater are our educational responsibilities. Millions of Americans in the Armed Forces through intensive Army training have learned to perform skills necessary to produce an effective fighting unit and to live successfully as soldiers. Every soldier who has served and fought with others from all parts of America, mingled with soldiers from Allied Nations and traveled to many countries of the globe, has had experiences which can be capitalized upon educationally.

These wider interests make necessary a broader educational program than would otherwise be required. The ramifications, as indicated, are very broad.

It is my personal belief that most of the men who are returning from overseas and who have been in the Armed Forces for sometime, from an educational standpoint, are better informed and more capable men than they were when they entered the service. Most have gone through periods not only of basic training, but many have attended specialized schools, and have acquired new skills. They have in many respects broader social outlooks. They do often return with embittered attitudes and much disillusionment. I believe that is understandable. I believe it is our job to begin, as indicated in the President's letter, a resocialization of the individual. The military experiences of men may be directed into sound educational and training channels that will assist them in rehabilitation upon discharge from the service.

Again referring to the manual (TM 8-290), Major Briscoe dwelt pretty largely on the first of the four points I wish to emphasize here. In Section 3 of Chapter III, pages 9 to 15 inclusive, is a discussion I will refer to as the "four phases of educational reconditioning." Major Briscoe discussed the personal adjustment that is necessary to establish that individual rapport between a man and the reconditioning personnel before any kind of reconditioning or rehabilitation can be made in restoring him to useful functioning as a soldier or as a civilian.

The second point is orientation and information to clearly state the issues for which this war is being fought, and the problems that lie ahead, also to awaken interest in the problems of every-day living.

The third point is that of counselling and classification which relates primarily to those things which motivate men, primarily with the men in the hospital. What are they going to do if they go back to duty? If discharged from the service, what jobs will they have or what opportunities for useful employment will exist upon returning to civilian life?

Then we come to the fourth point which is that of education and we covered that in the 31 courses in the detailed program of instruction.

Our job is just beginning. We have a start. The future looks very promising, but it is going to require a good deal of spade and shovel work to get this program started in the field.

In the manual (TM 8-290), Section 4, of Chapter III, there is a chapter on the administration of educational reconditioning activities. In paragraph 28 there is one short sentence I would like to call attention to, "Exacting, yet reasonable standards of performance must be demanded." We should recognize that the degree of absorption of men, the rate of accelleration, as far as the training programs are concerned, will vary with individuals. It is necessary that the standard of instruction and the standard of performance on the part of the individual, recognizing his limitations of capacity, must be maintained. Men will not have respect for a program that is haphazardly administered. There must be a well-planned schedule of classes, with as few deviations as possible.

There is nothing more upsetting to a program in a hospital, than to have a planned schedule, and to never find the classes in the rooms or the areas they are supposed to be meeting, or not to find the men in classes when they are scheduled.

The interest, the understanding and the attitude of officer, enlisted and civilian personnel that is working with the hospitalized soldier is most important in shaping the outlook of patients.

MAJOR BRISCOE: Lieutenant Kisker is going to tell us a bit about how to get these patients to become active civilians, and some of them active soldiers again, through the classification process.

LIEUTENANT KISKER: I find there is apt to be confusion on several points with respect to the classification and counselling function as to its integration in the total program. I should like to take up first, the overall picture, second, how it integrates with present programs, third, the matter of personnel, and fourth very briefly something on the matter of in-service training and materials used in the program.

I think that we should clearly understand that the classification and counselling functions within the convalescent hospital will relate specifically to these

three middle units described in chart 4 of ASF Circular 419.

Obviously with men flowing constantly to the convalescent hospital there must be some step before the men can be put into the classes. There must be some discussion, some contemplation of what the man has done in the past, what his capabilities are. If the individual is interested later on in returning to an academic life or if he hasn't completed his education or perhaps no interest in trades and wants to go into a profession, it will not be desirable, from a psychological standpoint to put him into one of the machine shop courses.

We do not intend to superimpose a plan on the man completely disregarding his wishes. Naturally from a mental hygiene standpoint that wouldn't be desirable. We want the man to feel that this is largely his decision and that can be accomplished only with skilled counselling.

The next step perhaps would be to institute what might be called specialized counselling. I shall recommend that all AGO tests be made available at that time. Many of the tests that may be desired at this point are not now available within the Army structure. Some readjustments will have to be made. A decision will be arrived at and the men will be programmed into the classes in the Convalescent Training Section.

The second problem relates to the categories headed by the box "Neuropsychiatric". The counsellor who starts with the man should, if possible, follow the same man throughout his stay in the hospital. That may be just a matter of discussing any problems that arise from time to time with the patient or with the instructors or medical officers.

The third aspect of this problem deals with the box, "Counselling and Classification." That is the time the man is ready to leave the convalescent hospital. He is either going to return to civilian life or he is going to return to duty. Again, it is desirable that the counsellor who started with this man, who followed him through, be the counsellor at this point.

I think our first big problem is going to arise right here. Most of the convalescent hospitals at the present time have a Separation and Classification Section. You very likely have an officer or perhaps two officers and two or three enlisted men in that section. Up to this time the separation officers have been concerned only with men leaving the service. There must now be a readjustment in the separation and classification work. We must now think in terms of classification and counselling for the hospital as a totality, with separation and classification being simply one phase of it. Under the suggested T/O there are four officers and 28 enlisted men. This amount should be sufficient to cover the program as outlined but it becomes necessary to integrate the present separation and classification work with the classification and counselling service now proposed. In a hospital such as Wakeman, where there is a convalescent hospital within a general hospital, the Separation and Classification Section at the present time operates only as a general hospital function. The question may be asked, "We already have an educational counsellor. Why shouldn't he do this work?" In some instances it may be quite possible to utilize your present educational counsellor in the proposed classification and counselling unit. You will need educational counsellors apart from the Education and Counselling Section. In general, however, the personnel for classification and counselling must be of a rather specialized type. The counsellor should have a broader point of view and a broader background than mere educational counselling, for the classification and counselling work. Army classification experience is desirable because we must remember that while Colonel Schwichtenberg indicated that a large proportion of these men would eventually return to civilian life, there will still be those returning to Army jobs, and it becomes imperative that someone within the classification and counselling unit be familiar with the Army classification system.

The classification and counselling personnel must also have a background in industrial trends, in job analysis, in, if you will, personal adjustment problems and a wide range of related matters. We have been training such personnel at the separation and classification school at Fort Dix. That training has been aimed specifically towards the man leaving the service.

As I suggested yesterday the personnel, "the 2235's" for officers and the "262's" for enlisted men should be requisitioned through service command head-

quarters, and if the service command does not have them available, we do have them available in our school pool, since we are driving personnel from ASF and from AGF for reassignment to the ASF. The personnel will be available for your needs if you make them known.

We have already set up an extensive service of supplying counsellors -- military counsellors -- with occupational and educational materials of all sorts, both for the orientation of our counsellors and for the use of men being separated from the service, or in this case, men, regardless of whether they are being separated or returning to duty. If soldiers are interested in jobs or interested in schooling we will have the information for them. In the very near future that program will be intensified through the assistance of the library section of Special Services Division. So there will be a heavy flow of materials needed in this program.

There is also an in-service training program set up for military counsellors. That training program is emanating from our office and being sent to the field. We will continue to do that and where necessary will change the emphasis to bring it closer to the convalescent program.

We are also at the moment in the process of compiling a technical manual, and in view of this development, there will be a section in the technical manual on an S.O.P. for classification and counselling units within convalescent hospitals.

I know that you gentlemen who are in command of hospitals have as a very real problem the number of other agencies to be considered at the time of separation from the service. There is for example, the multiplicity of interviews to be made then. War Department Circular 486, the one I mentioned yesterday, part 2, takes that problem into consideration. There has been a mistaken concept that interviews by representatives of various agencies is a compulsory matter, and as a result a great deal of needless confusion has developed. Such interviews are not compulsory matters as you will see when you refer to WD Circular 486.

The key to separation will be in the Classification and Counselling Branch. If it is felt that there is a need to refer a man to the United States Employment Service, the man will then be referred, but every man leaving the hospital will not automatically go to the United States Employment Service or to Selective Service or to Civil Service or to any other agency.

MAJOR GWYNN: We decided to make a few changes in the program which we think will make it a little more interesting and a little more compact. We are going to have all of the discussions in the evening session, so that you will have a chance to find out about the personnel situation, recreation program and things of that sort and then you will be able to discuss the whole matter this evening.

COL. THORNDIKE: I would like to make a few remarks concerning patient orientation. We have not been too well versed in the approach to the patient. With the changing policies due to exigencies of the military service -- combat and otherwise -- much of the orientation that was originally put out on reconditioning has not been modified.

We have the zone of interior hospital chain which consists of the station hospital and the regional hospital, which still can operate on the orientation program as it originally was formulated focussing return to duty and to military life.

Now the overseas patient is entirely different. I have been fortunate enough to have been overseas and seen them fresh and seen them on hospital ships and seen them in debarkation hospitals, and seen them in general hospitals. I think the one thing to emphasize is not the theme of "why we fight". I wish all the general hospitals would take that sign down. It is "why we have fought" and "why we may have to fight again."

You heard Major Briscoe and Captain Dittrick this morning discussing the problem of the approach to the patient and his bitterness when he arrives. Analyze that bitterness, and you find it is not too deep, and a good deal of the

gripe is founded on the fact that he has been evacuated through nine hospitals and this is one more. He has been told by the overseas medical officers certain things that don't seem to be happening to him. Misinformation has to be corrected. That is one of the first things to do in orienting the overseas case. He has been told he would have a thirty-day furlough at home, that he would be in the hospital nearest home when he gets here. These things may not happen.

Correct the misinformation. Try to analyze for him what the man has gained from his Army experience. He thinks he has lost, but he has at the same time gained. He has attended training courses. He has been to parts of the world that he never would have seen had it not been for the war and the Army. He is going home, looking forward with great eclat and great happiness toward that day when he gets home. Inform him before he goes, that home will not look the same, that the home town will be small, that the little road to the school house will be narrow and short, that he will see home through different eyes. He has seen new horizons, widened horizons. The same will be true of return to his former job. It may not be good enough to satisfy him after what he has gained in experience from the war. He will look for a better job.

It is just as easy to present orientation along those lines to the overseas patient and I am sure you will strike a note with him that he is looking for; you give him something to grasp, an attitude of mind to go away with, that points out to him that the United States is O.K. but it isn't as he used to think of it and all his old associations he will see through different eyes.

MISS VINCENT: I wonder if you could add one more point to what Colonel Thorndike has said.

I recently had an opportunity to visit certain hospitals in England and Normandy and I spent a great deal of time with the patients in the wards and had an opportunity to discuss with the doctors the fears and the hopes of those men and I think as never before we must realize that they are anxious to talk about a Supreme Being and to analyze their belief about right and wrong. In our future service I think all of us should take into consideration the service which those men are going to need from the Army Chaplain Corps.

I know the men who have been overseas feel exactly the same way. I know the Red Cross workers whom I have talked with in hospitals overseas say "please don't turn them aside when they want to talk about their experiences which many times is an impression of life and death." Everything that Colonel Thorndike has said I have seen and felt.

MAJOR GWYNN: I don't know how many of you know Miss Vincent, but she is the head of the Hospital Division of the American Red Cross and in her position she has been a good friend of the Medical Department.

The next item on the morning program will be given by Miss Messick of the Occupational Therapy Branch of our Division on

"Occupational Therapy in Convalescent Hospitals."

MISS MESSICK: The Occupational Therapy program in convalescent hospitals as set forth in ASF Circular 419 is as follows:

"Occupational therapy in the convalescent hospital will be conducted primarily as functional treatment for:

(a) Physical injuries in which the treatment for restoration of motion and strength, to injured muscles, nerves and joints has not been completed,
(b) And neuropsychiatric disorders.

Under the direction of the medical officer, occupational therapy will be conducted to meet the individual needs of the patient, according to his physical or mental disability."

Educational and Occupational Therapy programs should be correlated toward a more complete resocialization of the individual. Opportunity should be available in the occupational therapy workshops for screening patients for assignment to the pre-technical training section.

There will be need for functional treatment of patients with physical injuries. Such patients may be assigned to pre-technical shops where they may work on projects as other patients except their guidance and specific direction in respect to their injuries will be under the direction of the occupational therapist, as Major Briscoe pointed out yesterday.

It is the task of the occupational therapist to analyze the occupations and activities at her command in order to make the most intelligent use of their application as active exercise not only with regard to the specific condition to be treated but also the danger of such things as fatigue and compensation in cases of nerve involvement.

It is, of course, desirable that medical officers prescribing occupational therapy be familiar with activities and equipment available and the possibilities of adapting equipment and grading resistance to meet specific needs. The occupational therapist is professionally equipped to determine the activity which will produce the desired results, and at the same time be directed toward constructive activity.

May I emphasize the importance of prescriptions for scientific treatment of orthopedic, neuro-surgical and neuropsychiatric patients and the maintenance of progress notes.

Close cooperation with physical therapy is extremely important in this phase of treatment and it is important that the Orthopedic Occupational Therapy Department or shop be in close proximity to the Physical Therapy Department.

The place of occupational therapy in the treatment of neuropsychiatric patients is well known. Many of these patients in the infirmary or receiving section will be too sick to take part in either the primary or advanced reconditioning program and will be badly in need of occupational therapy. The activities offered should be sufficiently varied so as to not only be attractive but applicable to treatment needs. The Occupational Therapy Department will also serve as a testing ground in which patients may be placed. Many of these patients will be engaged in the educational and physical reconditioning, and referred for occupational therapy only when more individual treatment and observation is necessary.

The Neuropsychiatric Occupational Therapy Shop should be located near the Neuropsychiatric Section. Since neuropsychiatric patients will need to be screened before being assigned work in vocational guidance shops the occupational therapy shop may prove valuable as a sort of laboratory or testing ground for this purpose.

This is particularly true where vocational guidance shops contain power machines for neuropsychiatric patients. The occupational therapy program then should be closely coordinated with the educational reconditioning program.

Space for the occupational therapy shop should be well planned and where adequate facilities are not available construction of shops or adaptation of barracks buildings is possible. There should be two occupational therapy shops, one for neuropsychiatric patients and one for orthopedic patients. Construction of shops or adaptation of barracks buildings will be in accordance with plans now on file in the Hospital Construction Division of the Surgeon General's office.

Personnel -- There are two possible sources of personnel to head the occupational therapy program in convalescent hospitals. As you know, occupational therapy has not been authorized for convalescent hospitals up to the present time because all of our staff has been used in general hospitals. General hospitals are the only place where occupational therapy has been authorized. Transfer within the service command is the first possible source. This is the function of the occupational therapy consultant on the service command level.

The second possibility for personnel is that of new qualified people coming into the Army. These people will be ear-marked for convalescent hospitals when they have the proper training and experience. It is important to have top-notch people heading the occupational therapy program in convalescent hospitals. In cases where there is a general and convalescent hospital combined the senior occupational therapist who has been working in the general hospital will also direct the program in convalescent hospitals, as you know is being done in some instances.

The manning table authorizes four occupational therapists for 1,000 bed hospitals and eight for 2,000 bed hospitals, or one occupational therapist to each 250 patients, as has been authorized for general hospitals.

It is extremely important that personnel be selected on the basis of their training and experience in the type of work to which they are assigned. For instance, if a neuropsychiatric occupational therapist, or a person who has had more training along that line, and has had experience with neuropsychiatric patients is assigned to a hospital and suddenly she finds no neuropsychiatric patients there and has to work with orthopedic patients she is not going to do as good a job as she would if she were permitted to work with the type patients for which she is trained.

To meet the critical shortage of trained personnel the War Department has established an emergency course of one year's training in occupational therapy. The requirements for entrance to this course are graduation from a full four-year course leading to a bachelor's degree from an accredited college or university. Applicants must have had included in this course, or in addition thereto, at least twenty semester hours in fine or applied art, or in industrial art or in home economics with a knowledge of not less than three manual skills. Basic psychology is also a requirement. In recruiting students with these qualifications it was possible to accelerate the course to one year. The first four months are spent in civilian schools of occupational therapy devoted to medical subjects. The last eight months are spent in apprentice training in certain Army general hospitals designated as training centers.

The training of emergency corps students is authorized in ASF Circular 189, dated 22 June 1944, and ASF Circular No. 263, dated 15 August 1944, authorizes apprentice training for students from the approved schools of occupational therapy who have completed the didactic training. Since professional registration is being offered these students it is important that they receive well-rounded training. For this reason a training program was developed and is in effect in approximately 35 general hospitals. 100 of these students were placed in hospitals on the first of November. In this month there will be 68 additional apprentices placed in hospitals.

The first group of 100 students who went in hospitals the first of November will be graduate occupational therapists by July 1. It will then be possible to shift them to other hospitals. The plan is to train 600 such people.

We will have, by the first of February, 168 apprentice O.T.'s including the first 100, in hospitals, and 226 enrolled in the six civilian schools who are training students for us.

On March 1, 133 of these will be placed in hospitals. These 394 students will be in the various stages of their didactic and apprentice training work.

There are approximately 220 qualified and registered therapists in Army hospitals, which you see does not meet the need even in general hospitals of qualified registered people.

There are also approximately 60 apprentices from the regular schools of occupational therapy training in some phase of the work in Army hospitals, which is authorized in ASF Circular 263.

The manual on occupational therapy, which has been mentioned many times, TM 8-291, prepared by The Surgeon General's Office is expected to be available and ready for distribution in February.

This contains the basic principles and techniques of occupational therapy.

We expect shortly to have published a TB Med on occupational therapy.

You have heard many different times of the revised occupational therapy equipment list which will be available and sent to you very shortly. It is as nearly complete as it was possible to make it. And we hope that that will be in your hands very soon.

the basic principles of occupational therapy, the functional treatment, [illegible] of amputees and the purpose of occupational therapy for these people. The treatment of neuropsychiatric disorders, diversional activities and industrial therapy, the use of occupational therapy, industrial therapy, is also covered in the manual on occupational therapy.

MAJOR GWYNN: As Miss Messick is leaving this afternoon, we will have time now for some questions concerning her paper.

CAPT. ROBBINS: I would like to ask about Halloran General Hospital for enlisted WAC occupational therapy assistants.

MISS MESSICK: The course at Halloran has been set up for training enlisted WAC's who have signified an interestin O.T. So far there have been three to four courses planned. In the first group there were 17 students. Those selected were supposed to have been recruited among those who had some basic skills. They will only be assigned to hospitals which request them for use as assistants to occupational therapists.

CAPT. ROBBINS: Is there a quota?

MISS MESSICK: Requests for quotas are granted in accordance with the usual procedure.

MISS VINCENT: I should like to ask a question as to whether or not the chapter on diversional activities in your occupational therapy manual is one that the Red Cross will have an opportunity again to review?

MISS MESSICK: You have already reviewed it and it has been published without change.

CAPT. LICHT: It was mentioned that at the combined convalescent and general hospitals the senior therapist is in charge of both departments. That is a handicap. For instance at our hospital the installations are two miles apart. And I would like to ask that there be a professional O.T. at each place rather than to use both because of the resultant difficulties.

MISS MESSICK: The grades of senior occupational therapist for a convalescent hospital is supposed to be higher than that for the general hospital. We are still in the process of clearing this with the Civil Service.

COL. BARTON: In other words, you have provided the grade for a senior therapist in the convalescent hospital?

MISS MESSICK: That is right, and when I said that the Occupational Therapy Department in the convalescent and general hospital would be under the direction of the occupational therapist in the general hospital, it was in such cases as Walter Reed and Percy Jones where they have had to expand and where they have been able to meet that problem. If it isn't possible to meet it, I wouldn't see any reason why it couldn't be handled otherwise.

If there is provision for a senior therapist I think it would be within the province of the commanding officer to either indicate a juncture or a separation. I would be inclined to favor the suggestion that they be distinct, in view of the fact that they will have separate personnel and separate equipment.

MISS MESSICK: May I ask if, since the occupational therapist is administered under the Director of Reconditioning -- if there will also be a director of reconditioning assigned to the convalescent unit where there is such.

I mean will he be responsible for two senior occupational therapists who are directing work in two different hospitals or what will that administrative chain be?

COL. THORNDIKE: That is a Command decision.

MAJOR GWYNN: In order that you may understand about the rule of occupational therapy in convalescent hospital let me briefly read from ASF Circular 419:

"Occupational therapy in the convalescent hospital will be conducted primarily as functional treatment for 'M' physical injuries in which the treatment for restoration of motion and strength to injured muscles, nerves and joints has not been completed. 'P' Neuropsychiatric disorders. Under the direction of a medical officer occupational therapy will be conducted to meet the individual needs of a patient according to his physical or mental disability."

MAJOR BEELMAN: Is it your intention to utilize the services of volunteer Red Cross Gray Ladies, Arts and Skills workers in connection with the neuropsychiatric occupational therapy and reconditioning?

COL. BARTON: We certainly do. There are very few occupational therapists, as you all are aware. Volunteers recruited by the Red Cross to work in occupational therapy or the Gray Lady who has an aptitude and desire, who is placed there by the field director, and certainly the Arts and Skills units where they are available, will contribute a great deal to the completeness of the program and the service that will be rendered.

MAJOR BEELMAN: In connection with occupational therapy for neuropsychiatric patients we find that many of the NP patients like to engage in lighter forms of arts and crafts. They like to do leather work or felt, or light woodwork, and in the absence of graduate occupational therapists or a shortage of them, I think the utilization of volunteer workers should be encouraged. Under occupational therapy supervision, of course.

COL. THORNDIKE: I think I would like to emphasize the statistics that Miss Messick gave. You all know how critical this specialist personnel is. There are only 1500 occupational therapists in the country. In our general hospitals, we have over 200. That is one-ninth of the total registry. As you know the Navy has been procuring occupational therapists and on a commissioned basis. The Army will not commission.

Now, the schools will have graduated by the first of August 600 additional women who will then become apprentice therapists. There is also a small dribble of 50 or 60 from civilian schools who took the regular course but are getting their apprentice training in our hospitals, so perhaps by the first of August we can say we will have 900 therapists, 600 of whom will be in apprentice training.

MISS MESSICK: May I emphasize one thing, Colonel Thorndike, that is: These students who are in these civilian schools of occupational therapy for a four months' period are given, as I said before, medical work. Then they come into the Army hospital for additional training as well as practical work. They are not graduated until they have spent one year in the field and that means 8 months in an Army hospital has to be spent under supervision.

We promised these people an opportunity for professional registration and unless they are able to receive some training in all phases of the work, that is orthopedic and neuropsychiatric work, it is a question of whether or not the professional organization will register them or whether or not they can pass the examination for registration.

COL. THORNDIKE: They will still have to take the examination, of course, when they complete their eight months clinical apprenticeship but it is up to us to see that they get both orthopedic and neuropsychiatric training during that period.

I just want to point that out to the Service Command echelon to keep their eye on and see that they give them every opportunity to get the required training for their registration examination.

MAJOR JUSTER: Has there been any change in policy with regard to the pay of Red Cross Arts and Crafts work working in the same installations with the occupational therapists?

MAJOR GUYNN: Miss Vincent, would you like to answer that?

MISS VINCENT: I am not quite sure that I understand what you mean. We have heard recently that an arts and skills worker was paid to instruct WACs who are in training up at Halloran. That is a great surprise to us and the fact was not

known to Miss Messick. No volunteer who registered with the Arts and Skills Corps will be expected to be paid for her services in connection with the occupational therapy work in general hospitals or as an adjunct to recreation at station hospitals.

MAJOR JUSTER: We have an arts and crafts Red Cross worker and she is running a shop of her own. It happens that the occupational therapy equipment had not arrived, and so the occupational therapy hasn't had the opportunity to be set up so she has been doing the arts and crafts and she is a Red Cross worker.

MISS VINCENT: According to our agreement with the War Department, as a result of several conferences, the Red Cross Recreational Staff will not undertake arts and crafts in a hospital where there is occupational therapy but will be delighted to recruit such volunteers as are needed. In hospitals where there is no occupational therapist, the handcraft work is undertaken as one phase of the total recreation program. The Red Cross has not been requested nor are we undertaking occupational therapy in any Army and Navy general hospital.

MAJOR EASTMAN: ASF Circular 419 calls for occupational therapy in convalescent hospitals, and Miss Messick tells us that it is not authorized in convalescent hospitals.

COL. THORNDIKE: It will be by the end of this month when the supplies are available.

MAJOR BERLMAN: In the absence of a possibility of commissioned occupational therapists, will it be possible to give them officially "officer status" in hospitals? -- the same as enjoyed by Red Cross staff workers?

COL. THORNDIKE: We are in the throes of working out a procedure to take care of the matter of messing and quarters for civilian occupational therapists. It is General Kirk's desire that technically trained civilian medical department personnel be considered on an "officer status." We had a conference just before leaving with the hospital fund division who are working out a procedure for civilian personnel regulation 1-128, whereby that can be accomplished.

You will remember that regulation -- there was a deduction from pay of the ration, but in order to eat in the officer's mess there is a fee to be paid in addition to that ration. The commanding officer can collect that fee and have them eat in the officer's mess.

MAJOR GWYNN: I think everybody in this room is anxious to find out how they can secure the facilities necessary to carry out this rather complex mission of care in the convalescent hospital. We're fortunate today in having Major Loye of the Construction Division of the Surgeon General's office who will speak on facilities, requirements and construction policies relating to convalescent hospitals.

MAJOR LOYE: I have been asked to discuss facilities, requirements and construction policies as related to Army convalescent hospitals in the United States.

In dealing with the first part of this subject, the facilities of convalescent hospitals, a brief outline of the purpose and history of the program seems in order:

The reason for the establishment of the convalescent program in connection with the army general hospitals is to relieve the general hospitals of the patient in the convalescent phase of his recovery.

This relief permits the maximum utilization of beds for their primary purpose; that is, the definitive care of the severely wounded soldier returning from overseas.

The first step in the establishment of convalescent facilities was taken over a year ago with the acquisition by lease of several available schools and institutions near general hospitals, for the care of partially recovered patients. On the 7th of June 1944, ASF Circular 228 authorized the establishment of the Welch Convalescent Hospital at the former WAC Training School at Daytona Beach, Florida. Mitchell Convalescent Hospital, utilizing Camp Lockett, California, an old cavalry post, was also activated.

The program has since been enlarged, and is now firmly established as outlined by ASF Circular 419.

I should like to read you a list of other facilities added since the establishment of the first two at Welch and Mitchell. These are as given in WAR DEPT. Circular 352, 30 August 1944. It provides, with a certain reserve of the unallocated number, 29,500 beds for the completed program.

Old Farms Convalescent Hospital, Avon, Connecticut, is a special unit for the war blind. This fine permanent English Cotswold group of buildings is the former Avon School for Boys.

Fort Story Convalescent Hospital, Virginia, utilizes the hospital and post buildings of this coastal defense military post.

Camp Carson Convalescent Hospital uses the semi-permanent two-story brick type buildings of the former station hospital and other post buildings.

Then at the following seven general hospitals, large station hospitals or other facilities have been added for convalescent patient care.

Lovell General Hospital and the adjoining former Fort Devens station hospital.

England General Hospital, Atlantic City, with the Traymore Hotel, (since evacuated of convalescent patients).

Walter Reed with its annex at Forest Glen.

Brooke General Hospital, Fort Sam Houston, and the permanent fire-proof three story infantry barracks building near the post hospital.

Wakeman General Hospital, Columbus, Indiana, the former Camp Atterbury, has a two-story brick semi-permanent construction station hospital and utilizes additional post buildings.

Percy Jones has the Fort Custer Station Hospital as an annex, and T/O barracks for the Convalescent Training Program.

Madigan General Hospital, the old Fort Lewis Station Hospital, unit 5, is the new type one-story 1750 bed hospital, and it utilizes the post buildings in addition.

Camp Upton, New York, a former station hospital, has been added to this list. These hospitals will provide convalescent facilities as required by the regulation 40-1080, which has a requirement as follows:

"Convalescent facilities are buildings separate from fixed hospitals, for convalescent reconditioning of patients who no longer require daily medical and nursing care but who are not sufficiently recovered to return to duty. These building preferably should not be of hospital type construction. Whenever possible, they should be near the fixed hospital responsible for their administration."

The final paragraph of Circular 419 on convalescent hospitals is quoted as follows:

"Hospital Improvement: It is desired that the interior and the landscaping of each convalescent hospital be made as attractive as possible. Specifically, drapes, comfortable furniture, attractive decorations will be so employed as to give a homelike atmosphere to the hospitals. The natural surroundings of the installations should be enhanced by carefully planned landscaping and gardening projects."

With the establishment of the complete program as it is being initiated, assurance is given that the wishes of the President, in his letter of 4 December 1944, will be carried on; -- "that no oversea casualty is discharged from the armed forces until he has received the maximum benefits of hospitalization and convalescent facilities."

With this brief presentation of the overall program of facilities of these convalescent hospitals, I should like to outline the building and physical plant

The main divisions of course constitute the administration headquarters, receiving buildings for orientation and assignment; infirmary, or the station hospital facilities, reconditioning buildings, and the convalescent training units which include the services for occupational therapy, classification and consulting, educational reconditioning, class rooms and so forth, physical reconditioning, indoor and outdoor exercises, games, sports, and so forth.

The training facilities are necessary to serve the NP, primary and advanced reconditioning of patients. It was mentioned earlier this morning that separate facilities might be necessary for the neuropsychiatric patients and for the other type.

The housing portion of the convalescent hospitals has been determined to be allocated as for bed patients -- the 72 square feet per bed unit, -- and that requirement is carried for all of the housing of the entire area as well as the hospital or infirmary area. I shouldn't call it troop area. It is the patient area. Some interesting factors in amplification of the above outline help to clarify the problem of adapting the theoretical outline of the convalescent hospital just given to the building spaces available at the military post, leased school or other type of facility. For administrative headquarters, adequate and suitable buildings are provided for the many and varied activities. A rule of thumb guide in the allocation of space is a net figure of approximately 100 square feet per person assigned in the various areas.

For the receiving division the suitable spaces are assigned for the incoming patient to be processed. This activity is somewhat similar to the receiving section of a general hospital but is smaller and less complicated in scope.

For the infirmary division, a hospital is required for patients needing individual medical care and treatment. The size of this hospital, as given in the circular, should be 8 per cent of the patient strength in a convalescent hospital plus 3 per cent for the duty personnel. It is interesting to note that great demands are made on the physiotherapy and dental departments of these hospitals that have been taken over, and this demand has made expansion of those departments necessary in most cases.

Other changes in existing station hospitals have been relatively few, as clinical facilities are generally adequate for the light infirmary demands of the different classes of patients.

The reconditioning activities utilize existing gymnasia, pools, recreation halls, assembly halls, theaters, field houses, and so forth, wherever possible, with new construction in order only when necessary facilities are lacking.

Classrooms and shop buildings are often provided by utilizing existing buildings where located on the post, if conveniently placed, or by moving prefabricated buildings, or CCC buildings, for a more workable scheme.

Motor shops or garage buildings can readily be converted for courses in automotive vocational guidance.

Outdoor athletic and diversional activities, of course, must be a large part of the activities of the convalescent hospital.

Provision for riding horses, 4 per 100 patients, is being made at the Fort Story Convalescent Hospital.

This list of the activities -- athletic outdoor activities -- is somewhat similar to the program that we are working on for the general hospitals. The large categories are the athletic fields, facilities for baseball, soft ball, soccer and field hockey, handball, tennis, badminton, horse shoes, shuffle board, volley ball, basket ball, and so forth. In addition, the games, hobbies, sports, obstable training courses, gardening, golf, riding and swimming, where possible. Bowling alleys have been requested, but as yet have not been approved by Staff.

At first we had some little difficulty getting anywhere at all with our request for swimming pools at general hospitals. The War Department finally asked us to.

present a program. We requested thirty swimming pools that could be used all the year round. They seemed to be willing to give us those pools but only 9 were approved.

To follow on with the requirements for the convalescent hospital, the storage, supply, service and utility spaces, are adapted in suitable locations at the various areas.

I would like to give an illustration of just the facilities at one or two of the convalescent hospitals to show how this theoretical program has been adapted to the actual post. The Welch Convalescent Hospital at Daytona Beach, Florida, was established in June 1944 and occupies the former WAC Cantonment Training Facilities. This training center includes 175 acres of land plus 87 acres adjoining the civilian Halifax General Hospital which is of permanent construction. Cantonment wards have been added to increase the hospital capacity to 601 beds. This convalescent hospital was authorized at 4,000 capacity including an NP section of from 500 to a thousand for open ward NP patients. Total patients at present, I believe, are about 1800. The plan, of course, is to expand it to the full capacity. I don't know just when that will be reached.

There are seven battalion housing areas totaling approximately 8500 total personnel capacity and is laid out similar to the civilian military post with the battalion areas.

The necessary modifications included painting of both the exterior and interior, general repairs; radiator heat was installed in place of the unit stoves, ventilation fans in housing buildings, and air conditioning in hospital areas -- in the clinics and surgeries, and so forth. Public address systems were added. And then a list of conversion items. The administration buildings were converted from the existing buildings. Classroom buildings, shops, recreation buildings, service clubs, storehouses, boiler houses, theaters, repair shops, and motor pool instruction was moved to a new location; conversion of officer's quarters made to provide guest house facilities; storehouse buildings were converted to clothing issue and warehouse for quartermaster issue; new requests which have not yet been approved, there are the (1) new gymnasium, (2) a beach bathhouse, (3) swimming pool.

COL. COOK: An illustration I would like to give you is the Fort Story Hospital which was established in July of this last year, and that is of 1500 capacity as it was established, with 700 spaces for the opened NP cases. Two separate areas approximately one mile apart are utilized. This presents a little bit of a problem in administration, but as there are the separate shop and classroom facilities for each of the two branches, it works fairly satisfactorily. Adjoining the hospital area, that is in area No. 10 on the post, is the housing for the NP cases.

Area No. 6 is near the post headquarters and will house the primary and advanced reconditioning group. In the facilities approved there, two gymnasia have been provided because of the isolated groups of the two parts of the hospital.

Administration building. The outdoor exercise facilities have been located in the two different areas to provide service for each. The necessary conversion of the buildings was for the dispensary, for motor shops modified to class room buildings, the interior lining of three of the large barracks groups down there was necessary and approved.

Further modifications included provision for 16 shop buildings, 8 in the area near the NP section and 10 in the area for the large group. Those classroom buildings and shop buildings included music and assembly buildings, orientation and education building, and library, electric and auto electric building, auto and metal building, business and graphic arts building, woodworking and shop building.

In addition, the exterior work around the hospital was rather of large proportions because in that sandy soil down there near the beach it is difficult to carry on athletic activities in the sand that is soft and shifting, so that a portion of the area was paved to give a hard surface to be satisfactory for recreation.

These two cases at Welch and Fort Story give typical examples of problems in other convalescent hospitals and therefore will aid in the further development of the convalescent program.

The third and final section of the subject of construction policies, as related to convalescent hospitals:

Recent lessening of WPB materials restrictions, more liberal policies and interpretations and last, but by no means least, the President's letter of 4 December 1944, have simplified the construction policy problems.

A program is being initiated to provide adequate athletic facilities at all general hospitals for the benefit of convalescent patients. This applies as well, to the convalescent hospitals. Increased standards of maintenance are possible, including exterior painting, interior painting, floor covering, ventilation fans, improved hardware, air conditioning in surgeries and clinics of hospitals.

Libraries are authorized for general hospitals. And we have included a library in one of the classroom and shop buildings, as you may have noted in convalescent hospitals.

Nine indoor swimming pools have been authorized at the general hospitals with smaller outdoor pools for other hospitals. Nurses' call systems and public address systems have also been added.

The necessary speed to provide enough spaces, in time may mean that some discomfort may have to be overlooked for the present. This is true of the heating of prefabricated shops buildings, classrooms and possibly some housing, where stoves rather than radiator heat may have to be used until the boiler units and radiators can be procured. The shops, classrooms, recreation buildings, are to be finished on the inside and painted so as to facilitate cleaning and maintenance and provide a more homelike appearance.

In conclusion, let me say that the individual policy or construction problem of all the convalescent hospitals will receive careful consideration by The Surgeon General's Office. Our primary consideration is, of course, the complete and satisfactory establishment of this convalescent program for the care and prompt recovery of the returning soldier patient from overseas.

COL. THORNDIKE: Several things came out in Major Loye's paper. Exigencies of the war which we have described in earlier phases of the meeting have removed from the list of convalescent hospitals Camp Butner and even the Thomas B. England Convalescent Hospital at Traymore. The Traymore is to be turned over to be used for bed patients, class 4, as part of the England General Hospital, and the patients have already been moved to Upton. It is hard to keep up with the changing phases of war but there are actually, without Camp Butner, and without Traymore, 12 convalescent hospitals authorized, one of which is a special center for the war blind.

So, it makes 11 on this program that 419 applies to. You may expect further changes within the immediate future!

Now, I think Major Loye brought out a very pertinent point to you hospital commanders and those at the service command level, relative to the provision of the last paragraph in ASF Circular 419. If you have anything to requisition in the way of paint, in the way of dressing up your place with furniture and putting in curtains I would certainly requisition on that last paragraph as the authority, and get it in quickly.

Now, another surprising statement you heard was that horses are going to be available. I think it was last week General Somervell determined that there would be 4 horses for every hundred patients in convalescent hospitals.

The manning tables did not include a veterinary or his assistants, and it looks as though that would have to be authorized in the manning table.

Take a 4,000 bed hospital with 4 horses to a hundred patients, that is quite a cavalry squadron, 200 horses, Horseback riding will be an activity of recreation and physical recreation. Other problems are bound to come up.

Now, Major Loye, there is one thing I think that these commanders are vitally interested in, and that is the 72 square foot limit per patient. That is fixed, isn't it?

MAJOR LOYE: Y es, sir, that is very definitely fixed, because General Kirk is particularly anxious that these trainees, who are still classified definitely as patients, be classed at 72 square feet as far as the housing is concerned.

The places that have been made available are rather few and far between, and when they have been shown that they were available they have been selected, and there are disadvantages to all of them, but we are occupying the facilities that we have already in hand.

COL. GRABFIELD: I would like to ask Major Loye if he has any breakdown as to the amount of space that is required for these various shops for say, a 1500 bed facility or 3,000.

MAJOR LOYE: In the case of Fort Story, a little larger installation, there were 18 of these shops and classroom buildings. Two of the classroom buildings and 16 of the shop buildings. Those were 20x100 ft. buildings in the area, so that that will give you the gross area that they worked with.

COL. GRABFIELD: Were these warehouses that were converted?

MAJOR LOYE: They were CCC buildings, 20 by 100.

CO. GRABFIELD: Prefabricated buildings?

MAJOR LOYE: That is right. 20 by a hundred prefabricated, or T/O buildings converted.

COL. GRABFIELD: In other words, it would take 18 to implement this program?

MAJOR LOYE: That is in this particular case.

MAJOR BRISCOE: I might say that we have figures which can be offered later of the probable number of enrollees in each class.

We will be glad to present them at the proper time, with a suggestion as to how you may go about estimating the amount of space needed.

We will have ready, within a week at least, specific suggestions as to how you may adapt buildings to the needs of these classes and the probable amount of floor space which will be necessary.

Have you done anything or had any request for consolidating company messes, say four or five consolidated into one mess?

MAJOR LOYE: We have had that question brought up and I imagine as far as the operation is concerned that it would be a very logical step. We have had a similar request from Brooke in connection with the old buildings at the hospital to link two of their buildings, and provide a central officer-patient mess, which is a parallel request.

COL. GRABFIELD: I have one other question. This happens to be a problem of ours. It evidently is a problem elsewhere, too -- the necessity of using widely separated areas for these activities. H as any contact been made with ordnance to increase the allotment of motor vehicles, because some of these trainees will not be able to walk over these distances to these shops.

MAJOR LOYE: I don't know about the increase of motor vehicles, but at Camp Story there has been the suggestion that part of our building group serving the large group of patients be separated because they can use existing buildings.

AFTERNOON SESSION

COLONEL THORNDIKE: Will the conference please come to order?

I think everyone has been waiting for this afternoon to arrive. There is one thing of the morning hanging over, however.

Major Lumley, relative to Major Loye's last paper, has a few practical suggestions that he thinks one should take into consideration in designing athletic and recreation areas for the convalescent hospital.

MAJOR LUMLEY: Those of us working in physical reconditioning need some help, I think, on two counts: 1. We have a fundamental weakness in the organization of our equipment facilities for physical reconditioning. Let us consider hard surfaced areas, game courts, fields, other reconditioning equipment, gymnasia. These areas, courts and buildings, should not be dispersed around the hospital area except as batteries of the same kind of activities. This dispersal idea became obsolete in American colleges, schools, and playgrounds in the 1910-1920 period. These areas should be consolidated for administrative reasons, for competitive play, to make all of this equipment accessible to injured patients, to decrease the cost of construction, to increase their availability for all concerned.

For reasons of general morale in physical education we like to have the men play together where we can watch them. We are also interested in being able to prescribe specific definitive treatment for individuals. In the field of physical education we like to do as much individual teaching as we can. Therefore, I would like to recommend for consideration that someone with authority should issue a directive calling attention to the need for a consolidation of physical reconditioning equipment for Army hospitals. The gymnasium for the use of NP and convalescent patients should be designed as a remedial or therapeutic gymnasium. It should have a closed corridor between the wards and the gymnasium itself. It should be approachable by a wheel chair, therefore it should be at the ground level. It should have interior wood walls and no bleacher seats. We want the patients to have room to be exercised in. We want wood walls about 10 feet high, I think, because we want them to play games against that wall. We want to hang many kinds of remedial apparatus on that wall so we can use them. Therefore, I would suggest for your consideration a few small changes in the plans of gymnasia that we build in the future for the use of convalescent patients.

COL. THORNDIKE: Major Loye, do you want to comment?

MAJOR LOYE: On the first subject of the location of the gymnasium and of the general athletic and exercise facilities; in the general hospital program, at first, we had most of the program for larger facilities located near the gym and the exercise area, so that the free area in connection with general hospital was usually either at the side or at the rear of the service location. That was the only available large space. That presented one rather serious difficulty. The patient who was in a cast if he was in one of the surgical wards near the front of the hospital, had to travel a great distance for athletics. So it was suggested that recreational facilities be made available to him in the way of shuffleboard or the like. In that way he would be able to go out in, say, two or three minutes, and have a game and then come back to his ward. That was the reason I think for dispersal. It is dependent on how the buildings are arranged in each particular case as to where those facilities are established. I think that in the main that is the only objection to making all of the facilities available in one area at the rear of the hospital. It would also take a larger space. In the convalescent hospital situation, with the Class 3 patient, you have that same problem. Your convalescent hospital covers a larger area and do we want to replace all of those facilities at one centralized location if it means--for instance, down in Florida--going a great distance from one area to the center area. As it is arranged down there, we do have one center large athletic field, and subsidiary smaller fields with those facilities duplicated in the various areas. As far as the gymnasium plan is concerned, that was definitely, of course, made for athletic recreation for general hospitals and station hospitals. It was before our reconditioning program came up as it is planned today. We can place facilities around the outside walls of the gyms. However, I think the changing condition of the convalescent

hospital means that on those that we construct now might be modified with some of those suggestions adopted.

COL. THORNDIKE: I think that a general hospital setup must be looked upon from quite a different angle than this convalescent hospital that is developing rapidly. I agree, as far as the general hospital is concerned, on the way we have set them up to date. The only way you can get your 3's out is to have exercises next to those wards. If the general hospital is going to have only Class 4's, 3-C's and 3-B's, the 3-C's could still use those areas and they might not be able to use the gym. So with the changing situation in our general hospital, I think we have planned correctly to date in having dispersage near the wards.

Now, as to the convalescent hospital, I think that Major Lumley has something that ought to be taken into serious consideration. Where you ave many more Class 1's and 2's, and for the time being only 3-A's. I think we cannot experiment with dispersion ideas for the 3's until we know how many 3's are going to be sent. We have got to feel our way along if we have to build a supplementary exercise area next to a ward.

CAPT. LILLY: We have a limited number of strictly interpreted Class 3 patients and we have some facilities right near the infirmary. That is in addition to the central athletic area on which the bulk of the 1's and 2's participate.

MAJOR LUMLEY: Perhaps I am missing the point, but this idea of dispersal works all right for what we might call recreation, but, as I understand these convalescent patients and NP's, they have got to be led into taking some exercise. A great deal more organizational work has to be done. With the staffs we are obviously going to have, it seems to me we have got to get such things as--if you are to have eight volleyball courts, for example, at one installation, those eight volleyball courts had better be built on one block so that not only volleyball can be played at that area but a great many other kinds of games and kinds of activities, because those patients don't really want to exercise. They have got to be coaxed along and led along, and you are never going to be able to do it with your staffs in 30 or 40 different places at a convalescent center.

MISS VINCENT: When planning new construction in these convalescent hospitals, and it is necessary to establish a new Red Cross recreation building, are you planning to use the old type of construction or have you a new type of construction under consideration?

MAJOR LOYE: Do you mean a modified design entirely, or do you mean something that was a larger Red Cross such as your H-R 5? Are you familiar with that designation?

MISS VINCENT: Oh, yes. That is what I wanted to know: whether or not you plan to enlarge new buildings where they presently exist, or where new buildings have to be constructed whether you will use that same plan of construction.

MAJOR LOYE: I think that partially depends on the cost and feasibility of enlarging the new buildings, and also the possibility of using that for another purpose and then getting the larger building which would, of course, be more satisfactory. I think the money determines what will be done there.

COL. THORNDIKE: Have any convalescent hospitals developed Red Cross recreational halls?

COL. COOK: We have a small Red Cross building that came with the station hospital. It is adequate for the infirmary division, and as a Red Cross unit headquarters. At Daytona the Red Cross unit has had to expand into the field to take care of the convalescents, and we are now engaged in digging up office space for their interviewers and social service workers. I think in our program the Red Cross would probably not require recreational space in the trainee area, but they do require office space.

COL. THORNDIKE: Major Gwynn will now talk on "Recreation in the Convalescent Hospital Program."

MAJOR GWYNN: I am going to speak about recreation in convalescent hospitals.

I say that because the original meaning of the term recreation has been largely lost in the last few years, and every conceivable form of entertainment has been classified under the broad term of recreation. We all know very well that there are a good many forms of entertainment which we do not consider suitable for patients in our convalescent hospitals. I am talking about the refreshment of weary bodies and spirits according to the original meaning of the term recreation. We feel that is an integral part of our program in convalescent hospitals. This is not an added luxury to the scheme of things, but this is an adjunct to our therapeutic regime. Therefore, it calls for just as careful planning and just as much effort as my part of the program. In addition, it calls for very careful planning because our program of recreation in convalescent hospitals is going to be compared with recreation in redistribution centers.

The wounded patient in convalescent hospitals is going to ask the very logical question: "Why am I sitting in this God-forsaken desolate spot when I have been wounded, when my friend, who was not even wounded, is sitting around a luxury hotel enjoying himself?" We must find an answer to that question, and the only answer is to make his surroundings and environment as attractive as possible, to furnish a variety of good, wholesome beneficial recreation.

In order to plan a program of the nature I have explained, the people who are going to direct it and organize it must have a fundamental concept or philosophy of recreation themselves. It seems to me that something of this sort would fill the bill: that recreation is an essential area of freedom in which the person chooses for himself an activity that gives him the greatest satisfaction. In other words, this is a sphere that is peculiarly the patient's. It is his medium of self-expression in a program that might otherwise be termed somewhat regimented.

How much time is devoted to recreation? According to Section 7 of our Army Service Force Circular 419, at least one and one-half hours of the 8-hour scheduled day will be devoted to recreational activities, but in addition we feel that recreational facilities will be provided that will be so attractive that the patient will be stimulated to spend a great many of his off-duty hours on the post.

Besides, a great many of our convalescent hospitals are so located that the off-post recreational activities are few and far between, or wholly undesirable, so we will have to make up for that deficiency by our program in the convalescent hospitals.

There are two main types of recreational activities: individual and group. We want the patient, as I mentioned before, to do the thing that gives him the greatest satisfaction, and if that is an individual activity, that is what he should do.

One feels, however, there are certain advantages to group activities, particularly in the psychoneurotic group of patients, because it gives a man a chance to assume leadership again, and to participate in group activities which will help him regain his self-confidence. So we want patient participation as much as it is possible to do so without forcing it on the individual, and we want group activities.

One type of activity that we advocate is music of all forms--listening to music, playing music, all types of music--classical music, jive music, anything that the patient desires. Dramatics: we want him to participate in dramatics if possible If not, we are glad to have him attend as a spectator. Dances: one of the most popular forms of entertainment in our hospitals are the dances, and for that purpose dancing partners should be secured from the neighborhood, or if that is impossible, I have seen buses sent quite a distance to surrounding localities. I thi think that the patients would probably vote that one of the most popular of all their activities. We want them to have all kinds of games, individual games and group games.

Parties: the Red Cross has been very diligent in organizing parties in most of our hospitals. I have never even heard of some of these types of parties. They have shown a great deal of ingenuity in devising games and parties that the patients have found most entertaining.

Athletics: Some of the patients want to play golf or they want to play tennis and games of that sort, and this time is their time to use as they feel would be most profitably and enjoyably spent.

Picnics and outings and excursions to nearby points of interest are highly desirable. I think that all the patients are going to take a great deal more interest in the program if they are well oriented to the community that they are living in. Nearly every one of our hospitals is located in an area of some modern or historical interest, and special studies should be made of the possibilities inherent in the surrounding community.

As you heard this morning, one of the newer developments is horseback riding; facilities and horses will be available for riding.

Where does this entertainment or recreation, come from? The present policy is that our hospitals are glad to accept high class entertainment from any source from which it is offered. We believe that the Red Cross in most of our hospitals has furnished the bulk of the entertainment so far. Special Services has contributed a great deal to entertainment. Local interests have contributed. It has been felt that this entertainment must be coordinated, however. This is accomplished through the reconditioning council. I don't think I have heard the Council discussed much this morning or yesterday, but I believe you all know something about it. The Council is made up of the chiefs of services and presided over by the Commanding Officer with representatives of the Red Cross, Special Services, Chaplain, and all other agencies who are concerned with reconditioning, and it is at the meetings of this Reconditioning Council that allocation of time is made and schedule conflicts are prevented.

The Red Cross program in convalescent hospitals, we assume, would be similar to their program at present in general hospitals, but expanded. They have dances and parties, as I mentioned before, and I think you are all familiar with that type of activity. Special Services come into our hospitals now with four different activities: music, the presentation of USO shows and visiting celebrities, the drama workshop, which has proven very popular, and the library.

It was called to my attention yesterday that ASF Cir. 419 does not say anything about a library, but it is automatically called for in hospitals of more than 1000 beds.

As far as facilities are concerned, Major Love has discussed them in some detail. I think it is obvious to everyone that convalescent hospitals are going to call for far more in the way of facilities and personnel than the average general hospital. In the first place, at least in the beginning, more patients are going to be on their feet. They are going to have more leisure time probably than in most hospitals, and this time should be profitably employed, and it can only be profitably employed if we have facilities and personnel to do so.

In paragraph 19 of ASF 419 it says: "Existing facilities should be fully utilized and supplemented where necessary by alteration or new construction to carry out the mission of a convalescent hospital."

We feel that the mission cannot be carried out in most instances unless a great deal of thought and attention is given to providing proper facilities for recreation.

Paragraph 20: "It is desired that the interior and landscaping of each convalescent hospital be made as attractive as possible, specifically drapes, comfortable furniture, and attractive decorations will be so employed as to give a homelike atmosphere to the hospital. The natural surroundings of the installation should be enhanced by carefully planned landscaping and gardening projects."

We know that supplemental recreation halls are going to be necessary. I had some discussion with the Red Cross and with General Lull about this matter. There is a possibility that it would be desirable to have a type of club house which is used in the European Theater of Operations, which contains a snack bar. You must remember that these patients are going to have their supper very early in the evening. They are going to have a long period after that before their bed hour, and it is probably advantageous to have a room in which they can sit and write letters and

talk to one another and be able to get a bite to eat and perhaps a glass of beer. We know that the PX should be well equipped and should be of sufficient size to accommodate the number of patients at the hospital.

We spoke of a library. I think that a music library is also highly desirable. At most of the hospitals where there is a music library, it is a most popular feature

We took up swimming facilities and fields and gymnasia. All those have their place, and I think that enough has been said about them.

The day rooms, as I mentioned, must be attractively furnished. The men should have facilities for a barber shop, tailor shop, and to get shoes repaired. Those things seem elemental but I have been in a great many hospitals where they are not available. Patients are not going to enjoy themselves in their off-duty moments if they are going to a dance with a girl and their clothes are not properly pressed and their shoes shined, and I don't think that our hospital commanders want them making a sloppy appearance.

Personnel: there has been no special personnel granted for entertainment purposes. We are going to be dependent upon personnel from the agencies such as the American Red Cross and Special Services. Some of our regular personnel can aid to some extent but the bulk of our dependence will be upon outside agencies.

Recreation is an essential part of our public relations picture. We want our program to have just as many of the desirable features as any other program. We don't believe that our patients need to be turned loose to their own devices. We don't object to bringing in young ladies for dances, and we don't object to plenty of music. But we do object to furnishing the patient with board and lodging and then turning him loose to walk the streets of the neighborhood, or of the neighboring community. So, therefor, if this program is going to be a success, we must stress this recreational angle more than probably it has been stressed in the past. So, therefore, our public relations must be clarified and better interpreted to the public.

We want it stressed that we are putting these men through a program which is scientifically designed as a therapeutic measure to enable them to take their rightful place again in civilian life.

I will close by summing up the whole problem of recreation in convalescent hospitals by reading Paragraph 11,

"A recreational program emphasizing patient participation is an essential part of convalescent reconditioning. At least one and a half hours of the 8 hours reconditioning schedule ordinarily should be devoted to recreational activities. Additional recreational activities should be provided in order to make the convalescent hospitals as attractive to the patient as possible and to stimulate the desire among the patients to find diversion on the post during off-duty hours. The commanding officer, with the aid of a reconditioning council, should determine the activities of and the time available to the various agencies concerned with music, dramatics, dances, games, parties, arts and crafts, athletics, picnics, outings, and excursions."

MAJOR GWYNN: The next portion of the program has to do mainly with the Service Command Directors of Reconditioning or their representatives. Many times we hear comment that Washington interferes in the operation of service commands, and sometimes that may be true, but we feel that there is a place for higher headquarter activities, and one of these places is in the inspection of facilities in the field, to maintain a high standard of operation. I think that the Reconditioning Consultants Division realizes that it is a technical advisorydivision to the Surgeon General to aid him in formulating policy, and to maintain professional standards in the field by inspection, and to assist, upon request, Service Commands in accomplishing our common mission.

This entails obligations both ways. I will read to you Paragraph 2(d), War Department Circular 140, 11 April 1944. "Responsibilities of Surgeon General: the duties and responsibilities of a Surgeon General are as prescribed in Army Regulations. The Surgeon General may appoint professional consultants to keep him advised

as to the quality of medical treatment in the Army. The technical reports of such consultants will be forwarded to the Surgeon General through medical channels within the Army Ground Forces, Army Air Forces, or Army Service Forces, respectively."

We feel that we can be aided considerably in making plans for the future, and formulating policy, if we have more accurate and more adequate information concerning activities in field installations. We have distributed to you, this afternoon, a suggested check list to be used by Service Command Directors of Reconditioning, and their assistants in inspecting reconditioning programs. This is a suggested list. If you don't use this type of list, we hope that you will utilize a similar form. We are anxious that when installations are visited, that some such list as this will be made out and forwarded to our office for study and appraisal. I think that it will be helpful to you in evaluating the installation, and certainly will be a great aid to us.

COL. THORNDIKE: Relative to this check list, it is a suggested list from which, of course, the Service Commands will develop whatever inspection report they desire. But it is pretty all-inclusive. It involves four and a half pages of check marks, and can be done with relative simplicity in a minimum of time, and when summarized will give you a pretty clear picture of the program in that particular hospital.

Now, concerning recreation, Miss Vincent is here from the Red Cross and Lt. North is here from Special Services.

Miss Vincent, will you say a few words about Red Cross?

MISS VINCENT: Col. Thorndike, I am very anxious, while we are here today, to find out whether or not the officers in charge of the convalescent hospitals have as yet had an opportunity to determine the type of Red Cross personnel that they are going to require in the convalescent hospital program. I was interested in hearing Col. Cook say that he felt he would need more social workers than recreation workers. I was talking to someone yesterday who felt that we were going to need a large recreation staff because of the evening programs and perhaps we wouldn't need as many social workers. We are working on a table of organization for convalescent hospitals. We have several meetings with the Office of The Surgeon General next week, so that if the officers who are here from the convalescent hospitals could give us some suggestions, I know that Major Gwynn and I would be most grateful.

COL. THORNDIKE: Will the commanding officers of the convalescent hospitals speak with Miss Vincent before she leaves this afternoon, and give her a general background of the needs for Red Cross that your experience has shown you?

MISS VINCENT: As far as recreation is concerned, Major Gwynn has outlined what the Surgeon General's office is hoping we will be able to accomplish in the convalescent hospitals and I do hope that in our plans we can also include the services of volunteers because carefully selected volunteers will be able to contribute that interpretation to the community as to what the purpose of the reconditioning program is.

I have just one other comment that I would like to make about Red Cross service in hospitals, and that is that in the convalescent program our men are going to be very busy all day, and if the reconditioning officers and the medical officers will help the patients understand that if they need advice on personal or family worries, they may feel free to ask time to come to the Red Cross social worker. In the old days and in peacetime, the Army wasn't so rushed and neither was the Red Cross, so that the men did seek us out, the doctors could refer them almost any time during the day to the Red Cross social worker, and I think that we must remember that even though a man is busy all day, either exercising, or receiving educational advantages, that he is not going to get the full benefit of those unless he is free from worry, and that if people are sensible about it, then, they will refer them to us for help. When this new War Dept. Circular 486 is issued, that was referred to this morning, about the claims of personnel at the time of discharge, I hope that commanding officers of hospitals will make sure that the claims aspect of the man's discharge is given attention.

We are going to have further discussion on that next week and whether or not we will be able to send further statements to the field, I don't know, but a number of old-timers--and I am one of them--have found that as far as filing a statement for compensation is concerned, it can't be too optional. If it is a part of discharge procedure, he does it; he is not still wondering whether he should have done this or should have done that.

MAJOR GWYNN: Lt. North, as special representative of the Special Services Division of Army Service Forces, would you care to say something about this program?

LT. NORTH: I would just like to say that the entertainment section of the Special Services Division is very anxious to offer any assistance in developing a program of patient participation in dramatics. We have learned through experience that there are, in hospitals, a numbe of patients that are very anxious to participate in this type of activity. We have drawn up plans to submit for approval on the establishing of a drama workshop. This would bein any space available where patients could come and take part in any phase of dramatic production which would benefit them from the therapeutic and recreational point of view. For instance the construction of sets or the making of props or costuming, and also the mental stimulation in actual learning of lines. I think that it has been proven that this type of activity has definite benefit and I would just like to read a letter that was sent to us by a cast of patients at Tilton General Hospital who participated in one of these dramatic productions:

"We, the undersigned, all patients in the Tilton Hospital at Fort Dix, wish to express our appreciation for the opportunity of working and presenting the Special Services play "Hospital Daze.' It very pleasantly occupied three weeks of an otherwise rather dull and monotonous hospital convalescence. In the time we spent rehearsing and forming the play, we enjoyed ourselves greatly as well as learned a lot, and in the presentation of our show we believe gave a good evening's entertainment to our fellow patients. We hope that those of us who will be patients for a while will be able to form a nucleus of another group here at Tilton and present other shows."

MAJOR GWYNN: We will now take up the next feature of the program.

MAJOR BELLMAN: With reference to Red Cross activities. I am wondering whether Red Cross National Headquarters is contemplating assigning able bodied representatives, field directors, to hospitals, or the hospital representatives. They seem to have two kinds. The able bodied directors are at camps and stations and the hospital representatives are at hospitals and since most patients are ambulatory, I think that is quite an important point. Perhaps we had rather have men in the hospitals than ladies.

MAJOR GWYNN: Do you make that differentiation, Miss Vincent?

MISS VINCENT: Red Cross in camps is responsible for social service to able bodied men. Special Services is responsible for recreation for able bodied men. In hospitals Red Cross is responsible for social service to patients and duty personnel, and they have been responsible for recreation for patients.

Now, when you mentioned the fact that in some installations they were using able bodied men, I thought perhaps you were referring to the redistribution center that are located in various sections of the country, where, upon the request of Special Services, we have assigned certain men and certain women to help with the program there, but that is not a medical setting. To date, Col. Thorndike, I think I am right in saying that as it is medically supervised and under medical direction, The Surgeon General has requested Red Cross hospital service to be responsible. The very fact that you raise the question about men is just one of the things that perhaps we can discuss after this conference.

MAJOR GWYNN: I think it should be pointed out for the information of everyone here, that the exact relationship of these different agencies is under study at the present time and in the next week or two we expect that there will be a conference between The Surgeon General and the Director of Special Services Division and G-1 WDGS, in order to get this matter clarified.

MAJOR BEELMAN: There is one more question I had with reference to visiting hours in convalescent hospitals. Are there many patients in hospitals from nearby vicinities? What is the opinion about visiting hours?

MAJOR GWYNN: We are not entitled to have much of an opinion about it, because it is in the discretion of the commanding officer as to what he will grant, and it has been considered by a consultants division as trespassing on someone else's prerogative.

COL. THORNDIKE: It is a command function primarily.

MAJOR PATRICK: In connection with the library, I happen to know that the Army owns perhaps millions of good books purchased for use in ASTP under the specialized training program, and I was wondering if G3 had taken into consideration making some of those books available. A lot of them are technical. A lot of them are language books, history books and literature and others of that kind. I was wondering if they were still owned by the Army and if they could be put in libraries or made use of.

MAJOR GWYNN: Capt. Hall, who is a representative of the Library Service of Special Services, is here and I think maybe she could comment on that.

CAPT. HALL: I understood that a great number of those books had been requisitioned for use overseas. I was informed the other day that the Newport Port of Embarkation is at this time arranging for facilities for taking care of stockpiling and making available to overseas education people seven million books. Those are not available through our facilities. Our service has nothing to do with educational books, other than the fact that we have had some ASTP texts turned over to us. They have been circularized through the service commands as surplus property. When a station is inactivated, the library property is reported to us and we recommend through the service commands the disposition of those books. We would like to have requests from hospitals for those books.

COL. JENSEN: I don't remember the number of the directive, but there is a directive of the War Department that places all the texts owned by the War Department, purchased for the ASTP training programs, under the control of the United States Armed Forces Institute. That is where those books are.

CAPT. HALL: There is money for the establishment of libraries in new installations. For instance, if a hospital is a new installation or a new hospital, and it can requisition, I believe $7,000 for the establishment of a library.

MAJOR GWYNN: We will now take up the burning question of convalescent hospital personnel. I think we will change the order just a little bit as I believe it would be more appropriate for Captain Dittrick to speak now on the qualifications of the personnel. Then we will have Capt. Langhenry.

CAPT. DITTRICK: There have been a limited number of charts on personnel placed on the tables. The figures contained on this chart are embodied in the large manning tables which were distributed yesterday. It might be well to clear up one thought on which there may be some confusion. The term officially designated for the program of instruction is "Convalescent Training Section", and the program in that section of a convalescent hospital will be referred to as the Convalescent Training Program. The term "school" has been deleted from any further discussion or planning. On the detailed program of instruction, RTP 8-1, on the cover, the term "Convalescent Reconditioning Training Program" is used. Personnel, in my discussion, will relate entirely to that personnel which will be included in the Convalescent Training Program. A basic requisite that individuals who are going to serve in this program possess should be a definite belief in the mission that he is undertaking. If an instructor does not believe in this program, if he does not have a sincerity of purpose so far as the contribution he can make in rendering personal service and assistance to these patients, there is no place in the program for him. Secondly, he must have enthusiasm for the task he has undertaken. He should have skill and experience in that particular phase of the work for which he is responsible.

He must possess understanding and patience. The convalescent training mission is somewhat different than the Army Training Mission or an ordinary educational program. The rate at which men are going to be able to progress through courses will vary with each individual, and with his limitations, physical or mental. Understanding and patience with respect to individualized instruction is a prerequisite.

The instructor must be personable and possess tact and, lastly, but not least, he must be resourceful. He will come up against many problems that he hasn't anticipated and he is going to have to improvise and make use of the things at hand to do the best possible job.

As Major Cruze pointed out yesterday, as far as this instructional personnel, and the numbers which are indicated for each hospital, that is not meant to be fixed. This table is to be used as a guide. It will vary with local interests and local needs. It might be that a hospital will have need for more automechanics than are indicated and possibly fewer in the field of graphic arts; while another hospital may find that the provisions of the various specialists under automechanics is too great, and that they have a greater expression of interest in some phases of radio or electrical work or building construction.

The Director of the Convalescent Training Program is the key to this whole situation: much of the administrative detail, much of the direction of this program, must be planned by the man who is going to head this program. You will see that the specification serial number "2525" has been indicated. "2525" is a director of training. There happen to be, however, several other "spec" numbers from which you might find equally qualified officers: The TM 12-406, Officer Classification and TM 12-427, Enlisted Men, contains the job specifications.

The source of jobs that are given for Director of Training are school superintendent, college dean, director of vocational education. He directs educational and training programs for military or civilian personnel, reviews problems in which training is involved and prepares policies and programs for approval, organizes curricula and directs preparation and assembly of instructional material and equipment, formulates training standards, directs and supervises administrative and training activities of training units, and coordinates program. Military experience should include field and administrative experience in organization; should have civilian experience in public, private, or industrial education or training. That is the specification for the "2525". We then have three other officers whose requirements are quite similar; the education officer, "5500". I think you are familiar with his qualifications. In addition, there is the public education officer, "5503". Source jobs are university or college president, superintendent of schools, college dean, division chief of state education, department or office of education.

With respect to the procurement of officers to serve as directors of the school, it was mentioned briefly yesterday that a memorandum has gone forward from our office to personnel asking that a screening be made for officers who would qualify for a Spec. No. 2525, outlining the job and the requirements of this program. A few hours before leaving Washington, we received 29 briefs on such officers who were uncovered by reviewing the machine records. There is no assurance that we are going to be able to obtain 12, or whatever number you request, but the point that I do wish to make in that respect is that the requisitions must come from the service commands before such assignments of these officers can be made. You must determine your own need.

As Major Cruze pointed out yesterday, it is the intention that within the service command the resources for filling any of this personnel be thoroughly searched before requisitions be forwarded to the AGO through regular military channels.

Let us run down the list of officer personnel, and if you wish to take the chart on organization which is included--that is Chart No. 2 in 419--I will attempt to relate this various officer personnel to its appropriate spot on the chart.

Now, the Director of Convalescent Training, we have used the "spec" No. 2525. I have also given you 5500 and 5503 as possible sources.

Looking at the manning table, the education officers are "5500". That is the "spec" number that has been used for the educational reconditioning officers trained at the Personnel Services school in Lexington. Vocational and educational counsellors have "spec" No. 2235, one of which would be an assistant in charge of the department or subsection, as assistant director of counselling and classification. A training officer, "2520," will assist one of the "5500's" and head up the section "Chief of Administration." It will be his responsibility to coordinate schedules and lay out the schedule for the convalescent training program.

The supervisor of curriculum and instruction, it is intended would be one of the "5500's." Physical reconditioning officer, "5521," one would head the physical reconditioning branch. He would be the assistant director in charge of physical training.

The visual aid development officers, we have two indicated, "spec" No. 2685.--it is intended that one of these will be in charge of the film library. The other will coordinate and supervise the work of graphic arts.

The supply officer, it is intended will handle the supplies for the convalescent training program. He is a "4000" spec number. He will be under the chief of administration under the education section--his job consists of supplies and equipment, procurement and distribution.

Administration officers: two are indicated, "spec" No. 2120. One, it is intended, will handle the school guidance section under administration. The other will serve as supervisor and director of the business education department in the school.

The motor maintenance officer, "4805,"--it is intended that he will be supervisor of the instruction in the automotive maintenance course.

Communication officer, "0200,"--it is intended that he will supervise and head up that department of electricity.

The utilities officer, "7120," would head up woodworking and the power and light activities.

The music officer, "5241," will be in charge of the music instruction section.

We don't want instructors in these convalescent training sections who have never seen the inside of a class room or done any instruction either in civilian life or in the Army Training Program. Their job is going to be supervisory. They are going to have to take the six, eight, or ten enlisted instructors for whom they are responsible and organize each of those departments into an effective instructional unit.

Let us drop down the manning table to the administrative section, which is "Enlisted Personnel." I don't think it will be necessary to dwell on each of those. The "spec" numbers and the nomenclature are self-explanatory, but it is intended that that group will be responsible--or will provide the necessary help for carrying on administrative detail. As you read down the column, you will find that it covers quite a wide variety of skills. I merely repeat that this is a guide. The numbers that are indicated in the vertical columns may vary with the local needs of each installation, but again it is possible, and I repeat what was brought out yesterday: it will be necessary to conduct an in-service training program to provide initial orientation and indoctrination of this instructional personnel, as to the mission, the purpose, and the specialized nature of the convalescent training program.

MAJOR GWYN: We will now hear Capt. Langhenry speak about allotment and procurement of personnel for convalescent hospitals.

CAPT. LANGHENRY: I am going to talk from a few notes that I have made. Frankly, when I came in today my acquaintances--and I use that word advisedly,

because personnel officers don't have friends--my acquaintances all began telling me collectively and individually, "They are waiting for you."

First, I would like to congratualte the Service Command consultants on the professional job that you have done. Seemingly, you have done a wonderful job and I seriously mean it when I congratulate you. However, when it becomes necessary to discuss personnel, I must say that we think you have done a mediocre job.

The procurement of personnel for this program is the responsibility of the Commanding General of each Service Command, and not The Surgeon General in Washington. It is not our responsibility to secure one man for the program. That is your job. Our job is to train the men after you get them. That is our mission: to train men for the reconditioning program, not procure them. And you will find that statement is going to be made in a circular which is coming out, I hope, within the next day or so. It probably will be waiting for you when you return home. I have a digest of that circular with me, and a little later on I will tell you some of the new things that have been provided for you in order to help you procure personnel for the program.

Why do I say you have done a mediocre job? I hope to demonstrate it by a few case histories that have come to my individual attention. Twenty-nine physical reconditioning students are at present in the school. We in the Surgeon General's Office provided 19; you, in the Service Command, provided 10 of the students in the course for physical reconditioning now in this school. I think that figure alone, if I make no further statements, is a demonstration at least that you have done a mediocre job, as far as personnel is concerned.

Secondly, let me present three case histories of individuals. I will call them Lts. A, B, and C. First, the other day, Lt. A, a patient in a hospital in the Fifth Service Command for six months. In this particular hospital he had been used in the reconditioning program. He has been a Second Lieutenant for 20 some odd months. As a patient in the hospital he continued to work in the reconditioning program. A general officer in washington, called our attention to the fact that this man was doing an outstanding job. He remained a patient in the hospital, and no one recommended him for promotion or for permanent assignment. We called the hospital concerned and inquired about the man. At the time we did not know he was a patient. They said "Yes, Lt. A is one of the best men we have ever had in the reconditioning program." They were asked: "What are you going to do about him, Captain?"

The reply was, "Oh, he goes before a disposition board on the 15th of January. He will leave the hospital then."

I said, "What is he going to be?"

He said, "He is going to be limited service, continental limits of the United Staes."

"Have you thought about asking for him for the program?"

"No."

"Will you do it?"

"Can we do that?"

"Yes." They only asked for him for the program after we asked them to do so. And yet they admit he was one of the best men they have had in their hospital. That is Lt. A. He would never have gotten in the reconditioning program, I feel sure, if we, in Washington, hadn't had it brought to our attention by a general officer.

Lt. B, a hospital in the Fourth Service Command.Lt. B. Worked in the reconditioning program for a period of three to four months. When he left the hospital, disposition, limited service, Continental United States, the members of that hospital gave him letters of recommendation and said, "We would like to have this man in our reconditioning program." But did they do any more about it? No. He left

that hospital, went back to an assignment with a Coast Artillery Corps outfit and put in a letter begging to get into the program. That letter was cleared through all of his headquarters. He wasn't any good to them. He was in limited service, Continental United States. The hospital would have liked to have kept him in the program. Unfortunately something happened along the way to keep that man from getting in the program, but my point is this: if the particular hospital in the Fourth Service Command had asked for him, instead of giving him letters of recommendation, and said "We want him," we could have had him in the program easily. Ninety days before he ever could possible put in for the program we could have had him a permanent member and in the program.

The case of Lt. C. Lt. C. was a Military District of Washington case. Walter Reed General Hospital seemingly has a need for men in the program, but I would like to say this: that if you happen to be the consultant for a service command which fortunately has the program well filled in several hospitals, don't forget that the man who is in that hospital that is well filled, might be used somewhere else. This man in Washington happens to be a man who has but one arm. He was wounded overseas. He has a burning desire, gentlemen, to get into the reconditioning program. It is so burning that when Walter Reed sent him out on TD, to the Adjutant General's office to work in some little job over there, he went to the commanding officer of that particular section and said, "May I give a paper on reconditioning to all the people in here?" That paper I hold in my hand. It is a lovely story of the Reconditioning Program of the Army. I let Capt. Dittrick look at it the other day, and he said, "We can use that man." We certainly can use him. But why didn't Walter Reed take him? That is the question I want an answer to. Why didn't they take him? Why didn't they recommend him? Why did the Adjutant General, after he made a speech over there, come to us and said, "Why don't you get that guy in your program? You say you don't have enough help."

Well, I would like to use those case histories as evidence of the fact that in our opinion, gnetlemen, you have done a mediocre job from a personnel standpoint.

When you stop worrying about personnel, personnel begins to worry you, and believe me, that is true. I know it.

On the other hand, thanks to the Fourth Service Command--I can give them a boost now--I have received in my office yesterday a letter from a man who is in a detachment of patients, ASF Regional Hospital, Fort McClellan, Alabama. He sends this to the Adjutant General through the commanding officer requesting a chance to get into the program. The first indorsement by that hospital states--and I would like to tell you the date of that first indorsement--30 November.

"Attention is invited to attached extract from proceedings of Army Retirement Board. Lt. F. subject officer, while a patient in this hospital has demonstrated leadership and initiative in duties assigned to him with the reconditioning program at this hospital." The hospital didn't ask for the man. They don't want him in the hospital seemingly. They don't request his assignment anywhere. They don't build him up, they don't give him any backing in the job he is asking for, and yet they are short of personnel in the Fourth Service Command, and I know that to be a fact. They send that to the Commanding General of the Fourth Service Command. From there, gentlemen, by numerous indorsements it went to Replacement and School Command, then to Infantry Replacement Training Center, back to Replacement and School Command, to the Commanding General, Army Ground Forces, finally to the Adjutant General from the AGF, and then from the AG over to us, "Recommendation is requested." The reconditioning people have sent me a memorandum stating that they want this man and they want him to come down to this school for a reconditioning course. I received this some time in January. The man sent it November 30. Now, thank goodness for the new circular, because it certainly shortcuts such a procedure. Request for assignment now need only go from the hospital to the headquarters of the service command to the installation, the head of which has assignment jurisdiction; for instance, from the service command in this case, to the Commanding General, Army Ground Forces, to The Surgeon General, and back. We are going to cut out all that stuff in the middle.

This is proof that you can get men for your program. It is your responsibility to get them. Not ours.

I would like to talk about this question of authorizations and please, on all of your programs for the benefits of the Army Service Force Headquarters, Military Personnel Division, and so forth, cross out the word "allotment" and write in "authorization." You do not have any allotments in your service commands. You have authorizations. Bulk allotments are in bulk. Authorizations that are handed down by ASF to the various service commands are in bulk also.

I understand one question that came up yesterday had to do with the 14,500 persons required in this program. "Has the Service Command received that 14,500, are we going to get them?" Let me just take a minute to tell you how these authorizations operate. Military Personnel, the Director of Personnel, Army Service Forces receive requests from all service commands for personnel required to operate new installations. In this case, let's say it was determined that approximately 14,000 personnel would be necessary to operate the convalescent hospital program. When they receive that request, they ask the person submitting it to justify it as much as they possibley can. They then consolidate all these requests with the known personnel that they need, both civilian and military, and send it to the War Manpower Board. The War Manpower Board begins to slash. And let's say they slash 7,000. Does that mean that the 7,000 are from the 14,500 for this program? No. It simply means that the War Manpower Board will only allot to ASF in the entirety a certain number of personnel, both civilian and military.

Now, suppose they ask, let's say, for a million and they get 750,000, as the bulk allotment. ASF then must make authorizations to various service commands from that 750,000. When they allot to a service command, let's say, just as a matter of figures--I am not trying to quote any actual figures--let's say 100,000 to the Ninth Service Command, does that mean that in that hundred thousand are the necessary personnel to operate that program? The answer is, that is the Commanding General of the Service Command's problem. He has a mission to perform, and in so far as that mission goes, he must allot the personnel. That is the story.

Now, he has--this 14,500 in a bulk request to the War Manpower Board. They have given ASF an allotment. You, in the service commands, have been authorized personnel in accordance with that bulk allotment. The mission is yours. The service command general is responsible for making this mission work. He is responsible for seeing that the personnel is furnished. But you can't go to your military personnel division or Director of Military Personnel and say, "You have got 14,500, or you have got a thousand for this program. Give them to me." So what do you do? Well, first of all, you must determine what you need to operate the program and request it from your service command headquarters. They are going to give you your percentage of what they have to operate with, and no more, gentlemen, no more.

First of all, as I said, the mission is strictly one for the service commands. The procuring of personnel must come from the service command. We will help you, all we possibly can in Washington, and I think the fact that you have as many people as you now have is frankly our fault and not yours. The source procurement from now on is going to be largely limited to patients who, in the opinion of medical authorities, will be disqualified for overseas medical service. In other words, what you can get out of these boys in these hospitals, returnees from overseas, hospitalized returnees, is men who are not fit for overseas duty.

Suppose you have in your hospital a second lieutenant, infantry, returned from overseas, physically disqualified for overseas duty. I think most of you are familiar with Circular 403 which now states that limited service personnel that go before disposition boards and are determined to be limited service, unfit for overseas duty, must have a statement of essentiality, made by the headquarters having assignment jurisdiction. For example, we receive from the detachment of patients on all medical department personnel a request for a statement of essentiality in the personnel division of the SGO. We have to determine whether we want that man kept in the Army or put before a retiring board and gotten out of the Army. Attached to that disposition board coming in with this request for essentiality, commanding officers of hospitals now have the right according to the new circular I am describing, to also attach a request that if this man is otherwise not essential, they would like to have him for the reconditioning program. Now, that is a beginning. You ought to be able to get a lot of men that way, because when a man is unfit for overseas duty, the disposition board comes direct through service command channels into the agency that has the assignment jurisdiction. If they don't want him they will turn right around and go back to the service command and

say you can have him for the reconditioning program. That will be all there is to it and you oght to pick him up. That also holds good for enlisted men.

At the redistribution stations in your service commands--and you should work on those--attached tothe orders transferring the officer to the appropriate reception station for leave and processing, by an AG and ASF redistribution section, a statement that the officer is to be transferred on completion of redistribution station processing to the convalescent reconditioning program may be attached. Now, you have a better chance to pick them up.

We had Circular 348. We obtained only three (3) officers through that circular. That is all. Now you have a chance, under this, probably to put the screws on your various reception stations and try to pick men for your program.

We cannot assign anyone to a service command without the service command's concurrence. The Reconditioning Consultants Division cannot give you anyone for your program without concurrence of Military Personnel, SGO. Let's keep it in channels. Let's stop the practice of CO's of hospitals writing direct to the Reconditioning Division and saying, "Please send me Joe Doakes." When you do that, they come down to us and say, "We would like to have Joe Doakes." What do we have to do? We have to go right back to the military personnel of the service command and say, "Will you take Joe Doakes?" Then they say, "Will you send Joe Doakes?" Let military personnel ask for him. We will get him if he is at all available and give him to you.

CAPT. BLAINE: I would just like to say a few words in defense. When you get Carlisle experts up here who start laying it on the line, it reminds me of the time my wife went to Atlantic City and there was a man demonstrating a special vegetable shredder. He made the most beautiful and unique things you ever saw in your life and, well, I had to buy one. So she took it home, and after trying to use it for about three weeks, she finally gave it up and threw it in the ash can.

When Capt. Langhenry gets up and talks, it sounds so simple. Why don't we send in? Well, if a child gets burnt once and twice and three times and four times and five times, as we have done 50 times, after a while, you give up. You learn if you put your hands on a hot stove, you are going to get burnt.

Did you ever try to get anybody out of the Ground Forces? You might as well try to pull them back down from Heaven. So we come to Washington and they say, "We are going to cut your service command 5,000 but we are going to give reconditioning 1000, so, therefore, we are only going to take away from you 4000. "So where do some of the 4000 come from? Reconditioning.

Now, what is left? What do we have? They want only the best for overseas. They want full duty and full service men and they have got to have lots of zip. (Reconditioning Instructors have that, so they go.) So what do we get? Reconditioning gets what is left. So it comes to this: <u>we are getting less andless of worse and worse to do more and more with</u>.

MAJOR GWYNN: Captain Gracie will now talk on "Training for Convalescent Hospitals.

CAPT. GRACIE: The training of enlisted personnel for your hospitals has been a matter of concern to me, chiefly inasmuch as the particulr enlisted specialists that you need is the enlisted physical reconditioning instructor.

Class by class at the school, when it was at Camp Grant and now that it is at Fort Lewis, I have watched the requests go down and down from the service commands and I have wondered, as the program expanded who was handling the load of instruction. Who was performing the duty of the enlisted men that are intended to serve as instructors in the program. Our school has reached the point where we are seriously having to consider closing it for the simple reason the service commands do not send enlisted men to the schools. We don't receive the requests, under the present system of conducting courses of instruction in the ASF. We cannot burden you with the quota. Requests for quotas must come in from the several echelons under the present system, as I am sure you are all aware.

The Training Division of The Surgeon General's Office also supervises schools

that will train other specialists that you are going to need, specialists who appear on the manning tables that have been given to you here.

In addition to that, we are glad to advise and help you get courses in other schools. There is a new edition of the catalog of courses of instruction. Advance copies are already out. I don't know whether all of you are familiar with ASF Manual M-3. Its title is "Courses of Instruction given in Schools of Army Service Forces," and the issue that has just come out will list all the approved courses of all the services within the Army Service Forces.

Here you will find the requisites of the course, the description of the course, the length of the course, and by correspondence through the proper authorities you can find out the beginning dates.

The particular courses of interest to you in the Medical Department will be, I think the medical and surgical technicians courses, the dental and X-ray technicians courses, and now that we are going to have 150 horses plus, the veterinariane technician courses.

Also I notice in your manning tables that there are MEWT's, and 229 medical equipment maintenance technicians specified in the thousand-bed hospitals. They are rare birds, hard to find, it takes four months to train them and attrition rate at the school is high. I am very much afraid that you are going to have to send your own men to the school at St. Louis to take the Medical Equipment Maintenance Technician course, if you are going to maintain the elaborate and expensive apparatus that you will have in your infirmary and other parts of your hospital.

I have mentioned already, as an unpleasant introduction, the course for physical reconditioning instructors at Fort Lewis. That is a six weeks course. The next class No. 6 is reporting on the 13th of this month and there will be a class No. 7 reporting on 24 February.

I might say, so far as capacity is concerned, that with present utilization of that facility, the capacity is unlimited. So if you will write through the channels to the Training Division, SGO, we will be glad to allot quotas to you.

I might mention, too, that I have heard in the discussion of enlisted personnel here, no mention made as yet of the utilization of WACs, in various capacities in convalescent installations. I remind you that we conduct one school exclusively for WACs, WACs to be employed as technicians in the Medical Department.

The method of obtaining quotas for all courses listed in the Manual M-3 is set forth in Paragraph 109 of ASF Manual M-4 which is Military Training. That rather simple procedure of obtaining quotas is apparently uncommon knowledge in too many quarters. It simply means how that when you want to send someone to a school, you ask Service Command to get the quotas for you, Service Command asks the Chief of the Technical Service concerned, who, in turn, allots the quota to the Service Command, and it is sub-allotted to you.

In matters of information pertaining to courses of instruction, you are authorized to write direct to us and we will be glad to tell you any specific details that don't appear in Manual M-3. However, I think you will find in that general compendium of information about courses, the answers to practically all of your questions.

Also, I want to mention the fact that Medical Administrative Corps Officers Candidate School is still being conducted, both at Camp Barkley and at Carlisle Barracks. It is quite possible that in some of your patients there will appear men who have officer potentialities who will meet the physical standards set up in Change 1 to AR 625-5 and who will be able to attend Officer Candidate School. Quotas for Officer Candidate School are allotted after the candidates are accepted and not allotted in advance.

One of the greatest sources of correspondence we have is from individuals either within the service or outside the service who know, either from personal experience or hearsay, of applications for Officer Candidate School that are not considered by authorities who refuse the application on the ground that no allotment has been made. The allotment of quotas, I repeat, follows the reporting of

accepted applicants to the Adjutant General and is not made as a matter of course. If we, in the Training Division at SGO, can set up courses which will help you to meet needs not covered by existing courses or which cannot be filled by the conversion of existing military occupational specialists, we will be glad to work with you in handling that problem.

In order that tonight's meeting, which will be a round table discussion, will be handled as expeditiously as possible, it is requested that during this recess, that you will print what questions you may like to have discussed, and leave them upon this desk.

COL. GRABFIELD: I would like to rise to the defense of the Service Command by citing another case history.

We will call him Lt. D, not A, B, or C, who was a patient in Lovell General Hospital, and during his convalescence was very active in the reconditioning program. This officer was extremely valuable to us, so, letters were written requesting that this officer be transferred from Ground Forces and assigned to us, and the letter wormed its way in and out through various channels. Two or three tracers were sent on it, and finally it came back with complete wonderment on the part of the authorities, to ask who this officer was. They apparently lost track of him. So it went its way back by indorsement, in which we assured them that such an officer existed and that he was there and that we still would like him and that he still was continuing to be of good service, and it took four months to get him assigned. That is in defense of Service Commands, so far as trying to get officers. However, the new circular will probably help that.

I would like to say something about this personnel organization. Capt. Langhenry has pointed out how you get your personnel and being a personnel officer as well as a reconditioning officer, I can tell you how it works, at least, in one service command.

We are told we have this new activity. By Capt. Langhenry's figures, there was allotted over all to the ASF 14,500 men to implement this program. Those were additional men over and above our present authorization for all the service commands. That is, to man 29,500 beds, I gather, which gives you a total over-all personnel ratio of approximately .48. The suggested manning table for the thousand-bed convalescent facility calls for .65. For the 2000 calls for .54. Now, it is perfectly evident that if ASF gets only .48, we can't approach that. I think we ought to be realistic about these things, when we are putting them out. We immediately got busy on this after the Service Commands Surgeons' Conference and pulled out of the blue for our facility a figure, by joint conference with the Personnel Director, Personnel Control Division, the figure of roughly 600. We figured it on .4 because General Dalton had telephoned us and said that we were going to be authorized .4 in the case of a convalescent facility attached to a general hospital. In other words, for us, with a 1500-bed authorization, we would need 600 people. We sat down in the office and figured it out on the basis of function--this is before we saw any of the material here--and we came to 622 as a minimum personnel. As I told you, we telephoned to Boston yesterday and put in a telephonic request for 600 and got 500. If we are going to get 500, that becomes a ratio of .33 for our convalescent facility.

In other words, approximately half of what we are dealing with. Now, we can dig through the Service Command. It also should be remembered that these service commands have been pared down and pared down, just as Captain Blaine says, and it is not only the Medical Department.

I happen to have been fairly close to the Manpower Board representative in our service command, have been with him on all his trips to medical installations and on some to other installations, and our Service Command--I think this is true of every one of them--has been pared down in every activity until there is no fat left on the skeleton. And that is the reason we don't send them to school. Until we have got the absolute minimum to operate the installation, no one in this room as a commanding officer is going to send a man to school if his place is running.

In addition, quality of personnel should be taken into consideration. As it stands now, quality of our personnel is preponderantly past 3, 4, and 5 intelligence, and that kind of personnel doesn't go to school and make anything of itself.

If you can use them in the hospital and make full use of them, or at an installation, you are doing about the best you can.

So, unless we can find Class 1 and 2 personnel, unless it can be provided somewhere, unless somebody can suggest how we get it, we haven't got anybody to go to school, and I am not going to push, neither is any Commanding General, going to push his people who are down to rock bottom, to lose people to school for four months when he can just barely get along with that quality of personnel that is at his installation now.

That is, it seems to me, the essence of this whole personnel problem, the whole school problem. If we cannot get the War Manpower Board--and there is, I am sure, because I have heard it--very good reason why we can't do it--to give us more personnel, personnel available for school, personnel available for expansion is going to be an altogether too little to do much more than what we are doing right now.

With this extra 500, we can and we will make this program go, but we won't be able to make it go on the full manning table, the impossible. We won't get it.

Transfers within Service Command, yes, you can get your Service Command to make Machine Records run. You will probably find that the personnel you want is occupying key positions in the MP battalion or the personnel center, or the ASF Training Center in your Service Command, and that Commanding Officer is going to say, "Yes, I would like to give you this man, he is a fine automechanic, and he could teach automechanics, and I am sure he could do it well, but he is my sergeant major or he is first sergeant of this, or he is running this, and he is the only one I have got." You run up against that. It may be that you will get some. We must remember that these manning tables are guides and that your service command personnel officer won't get more people except in one of two ways--by hiring civilians, and that isn't always possible, and there is a ceiling on those--and by getting more people out of here to the ASF for this program by the War Department Manpower Board.

MAJOR GWYNN: 14,500 men were authorized for the 19,500 convalescent beds, only 10,000 beds being held in reserve.

CAPT. LANGHENRY: I would like to make this comment. Maybe I will give you an idea here. I am not asking for work, but there is an answer to Capt. Blaine and to Col. Grabfield's case history of Lt. D. I might say that we have no trouble at all getting an officer from the Ground Forces for this program, if he is not troop age and physically fit for general military duty. If he is physically fit for military duty, War Department regulations definitely say you cannot take him and we don't even ask for him. However, if Col. Grabfield, with his case history of Lt. D, had directed a letter to the Military Personnel Division, Surgeon General's office, outlining the qualifications of this man for the program and asking that we attempt to get him assigned to his Service Command for that job, we would have taken his letter to the Reconditioning Division and say, "Do you want this man in your program?" They would say, "Yes, get him." I merely pick up a telephone. I call the army Ground Forces Personnel. I tell them that I have a man who is a patient in a hospital such and such a place who is going to be limited service, Continental United States. They will say, "Take him." That is all there is to it--"Take him." I hang up the telephone. I issue the orders and the man is assigned to the First Service Command.

MAJOR GWYNN: Now about this situation: recently the Air Force let a number of men go who had been working on their reconditioning program and these men apparently were assigned immediately to the Ground Forces. We have received a lot of requests wanting to know if these men who had been trained in this specialty could not be obtained from the Ground Forces.

CAPT. LANGHENRY: The answer to that is: if they are full military duty and troop age, you are not going to get them.

COL. STINE: I would like to ask the captain why it is that I have in my files an indorsement from the Military Personnel Branch of the Surgeon General's Office a refusal to a request for the assignment of four enlisted men, limited service, Ground Forces, confined to the continental limits of the United States, back from overseas, that I personally requested?

In your new circular, the men that we can get assigned, must they be overseas men?

CAPT. LANGHENRY: I tried to make it clear that you could get men who were not fit for overseas duty, whether they were returned from overseas or whether they were in this country: and, answering your other question: I don't happen to handle enlisted personnel, but I am sure that if you received an indorsement back from our Division which said they were not available, it was simply because the Ground Forces had another job for them and didn't want to let them go, and that is not always the case.

CAPT. LYON: I would like to comment on a slightly different angle. The problem we have with reference to this personnel is that the personnel that is qualified under ASF Circular 348 as educational reconditioning officers, and trained in the school, is in most cases not personally fitted for the job. I will give you a few specific statistics.

I have been in service command headquarters about three months. I haven't checked every hospital, but at the present moment I don't know of a single educational reconditioning officer in any hospital in the Fifth Service Command who is a teacher or who qualifies with a background of teaching or other educational experience. Not only that, but the personnel in that service command has been turned over about a hundred percent since I have been there. They do not have those traits that have been discussed here particularly by Capt. Dittrick as necessary in order to carry on this program.

A commanding officer told me just a few days ago that I had to get rid of an officer trained in this school, MA degree in physical education. As a matter of fact, incidentally, the only good education officers I have got in the Service Command are physical reconditioning men. These men, almost all of them, have been trained in physical reconditioning. I hate to have to admit that, being a college professor of education, but it is the truth. We must go beyond just saying that personnel can be assigned, personnel can be got, we can send personnel down to this school. Men who have superior qualifications aren't going to stick on the job. This is the hardest job in the world. It is the meanest job you ever saw.

MAJOR BRISCOE: I would concur entirely with what the Captain said with respect to the qualifications of men to run this program. I am reminded also of what Capt. Laughenry said: if you get good men into the program, they will almost all have to be picked by you on the ground from those that are available. I don't know any way, by paper qualifications, to judge whether a man will be a good leader of men or not. From personal experience over a good many years, picking into thousands of teachers and principals for a large city school system, I don't know any other way than to try a man on the job to see if he makes good.

I am sure of one thing, that a Ph.D. degree or a Master's degree or any degree is no assurance that a man will be a good teacher or a good leader, and while we set up those qualifications it is important that the person be a man among men, and have some enthusiasm and some energy, and that he have intelligence, good horse sense, and if he has that, I would take a chance on him regardless of his degrees. The kinds of things patients want to talk about are every day problems.

Col. Barton touched on some the other day. Orientation. Your boss bawls you out. What are you going to do about it. Things like that.

I am getting a little off the topic, but I want to come back to that one point, that from the men who are coming back from overseas, you are going to have to be alert to find those who have ability. I personally have found at least nine top men who are doing good jobs at various places over the country, and I am sure you can find the same number, and if everybody in this room found two that would go a long way toward providing the desired personnel.

CAPT. BLAINE: There are a couple of things that need to be looked into: namely, in our 10 General Hospitals, 76 per cent of the patients in the hospital were participating in some form of reconditioning. In the Regional Hospital 70 per cent were participating in reconditioning and in the Station Hospital 63 percent. We looked then at the number of officers. In General Hospitals there is one reconditioning officer for each 300 patients in the hospital; in Regional Hospitals there is one for each 400 patients in the hospital; and in Station Hospitals there is one

officer for each 500 patients in the hospital.

Now, how can we send a man away to school?

Then, there is another point. You say that these patients are from overseas and send them into school. Well, the school has certain qualifications and if a man can't reach those qualifications, will you accept him?

COL. JENSEN: Surely.

CAPT. BLAINE: We had an enlisted man. We wanted to send him to Fort Lewis. He was the only man that we could spare to send away and he proceeded to flunk. He wasn't up to standard. We know he wasn't up to standard, but we sincerely did want to send somebody and we couldn't spare anybody else to send.

COL. JENSEN: Several problems have come up here that are yours and mine and the school's. Let me qualify the positive "sure" that we will take them. The way the school operates is this: we do not turn any man away who is sent here on orders to be trained unless he is failing and unless he does not have the educational qualifications, and unless he desires to return. No. 1. We don't care what his qualifications are. If he can make the course, that is fine. No. 2. If he is failing and he isn't well qualified to take the course, it probably means that he isn't working; that is his own hard luck. But if he is not qualified and does not have the educational background,--let's say he has an eighth grade education and he is failing,--we feel that the man was improperly sent to the school, that it wan't his fault, that somebody else issued the orders on him, and if he wants to return to his home station, he may.

Now, the men who we know are going to return to reconditioning, whether they pass or fail, we hold extra classes for evening sessions. We go to almost any lengths to try to help them get through, because we are aware of the fact that they are going to work in reconditioning whether they pass or fail. This is an ASF school. It is a Class 4 installation under General Dalton, and our program of instruction is checked and approved by ASF Training. And the grading of examinations and the evaluation of students is in a research division--that is, a division that does that for all the different courses that are taught here at the school. I don't have anything to do with that. I don't grade a single paper. I don't work out a curve. They tell me who flunked, they tell me who passed.

Now, there is one other thing I think we are all up against. America is up against it. One thing we don't have the most of is manpower. I imagine General Eisenhower can tell you the same story about the Western Front that we have heard here today, but we have got a war to win and a job to do. And we have got to do it with what we can get our hands on. And it should be our constant mission to upgrade the personnel we can get our hands on. We can do as much as 24 days allow us here with the men that come to this school, though they are certainly not well trained or qualified officers for reconditioning, either education or physical, when they leave here. Many of them, the great bulk of them at the present time, have never seen a hospital except to get their toe wrapped up in it. A great many of the people that are now in the present class in educational reconditioning have only had basic training. That is all they even know about the Army. When we teach a class we have to be careful not to use such terms as "MAC" because they don't understand what you are talking about. These are the available people at the present time. They are all we have and you, as consultants, must do your level best to upgrade those people when they get to you and make as much as you can out of them, or we are never going to have enough.

I think we have all got the same problem and we are not going to find enough people of the quality of leadership that we would all like to have to do this job, because everybody in the Army wants them. We will maybe get our share. Nobody has enough of them, and it is our job to make as much as we can out of the rest of them. And it certainly doesn't solve the Army's problem to have someone failing your work, to send them to somebody else so they will fail there, so they send them to somebody else so they will fail there.

CAPT. DITTRICK: May I supplement the point that Col. Jensen has brought out and concur in the expression by Major Briscoe: that if we pick men with intelligence

and interest and enthusiasm, regardless of whether they have that Ph.D. or M.A. or even an A.B., that enthusiasm, that interest is going to carry them a long way.

I would like to make one point so as not to confuse the General, Regional, and Station Hospital problem with that of the Convalescent Hospital. As I understand it, our chief concern here today is the Convalescent Hospital program. Yeserday I intended to make a point of the fact that because of the urgency of establishing this program, these technical instructors, by "spec" number, that have been given to you, are going to be found as rapidly as possible or supplied by Personnel in Washington upon request from the Service Command if they aren't available in the Service Command. There is not going to be adequate time to send personnel to Lexington. It will be necessary for leadership to be deomonstrated on the job. During the early stages, indoctrination in the mission of reconditioning may have to be done from 1900 to 2200, maybe five nights a week, but it is a job that must be done and it can be done.

Another point as far as the General Hospital program is concerned--I have probably visited 15 different hospitals and in no instance have I ever seen an in-service training program being carried out in a hospital. I am wondering if the education reconditioning personnel are not missing a bet to improve the kind of program that they have on paper.

Another point that I wish to make that I think is too common, and that is the educational reconditioning personnel, frequently officer and enlisted alike, are spending too much time in their offices. You can't run an educational reconditioning program from behind a desk. You have to be in the wards.

CAPT. BUCKELEW: I can't imagine a more difficult job than to attempt to run an educational or physical reconditioning school, and I think too often we find that we take for granted when we send a person to school that they are all set when they come back. I recall an interesting case in which I sent one of our very valuable reconditioning soldiers down here and he promptly flunked out to his great embarrassment. Col. Stine then got him. I lost him and he got the best man I had.

Industry had this same problem and they solved it and here is how they solved it: if you are not acquainted with on-the-job training, and if you are not conducting your own on-the-job training, then, you are courting failure in your program.

Five thousand two-hundred twenty manhours were spent in Cushing General Hospital in the month of December in on-the-job training. Now, it can be done. Don't tell me that it can't be done. It pays off, gentlemen. It is your only escape. Meet this challenge by making use of that which has been proven in industry in a similar situation. It has been done and you can do it. I shall not go into the mechanics of JST and JIT, but I think we must not cast the accusing finger at our school courses here, either physical or educational.

There are no training difficulties in Cushing General Hospital.

CAPT. LYON: I would like to speak on this point. We have on-the-job training program in our service command--in fact, we initiated that program because of our problem which I indicated. For about three months we sent all of the officers, the new officers that we got who were coming to the school or going from the school down to the hospital, that was supposed to have the best program in our Service Command, and they had a two weeks on-the-job study, visitation, and evaluation. The plan worked so well that Col. Preston suggested that we make it more definite, and during the first two weeks of December we pulled in one officer from each one of the hospitals in the Service Command--two chiefs, about half education and about half physical reconditioning officers --and had them follow through on this two weeks training program. During that time I was at the hospital and directed that program. We found it highly satisfactory.

COL. ALBUS. I think we were probably one of the first ones to ask for material or personnel from the Ground Forces. Initially we were successful. Recently we have been very unsuccessful, and so unsuccessful that our service command personnel group refused to request any more until I wrote the endorsements myself, and still they came back "No." That is so far as that is concerned.

There was a question about utilization of WACs. We have been doing that at Percy Jones with a great deal of success, even to the point of physical reconditioning instructors and enlisted WACs. We accomplished that, of course, by on-the-job training. We have not been able to send very many people to school, because the people are not available within the service command to send to school.

I would like to raise a question which hasn't been raised here as yet, and I don't know much about it myself, except that I understand that at the Service Com-,and Surgeons' Conference they were advised that it would only be a very short time until all of these men who have been so far exempted from being transferred to the Ground Forces and so on, who are in scarce categories, would be taken away from us. That, of course, would include our reconditioning personnel which have so far been immune since they are considered as being in a scarce category. That raises a problem which hasn't been brought up, which just adds another one to the file.

With the question of picking up casualty personnel--returned battle casualties-who are unfit for field service or overseas service, I am unable to see at the moment how they can qualify, for example, in the enlisted group especially, for training as physical reconditioning instructors. This on-the-job training is fine. We like it. I have one station hospital whose entire enlisted personnel on reconditioning, not one of them have been to any school, yet they have a very successful program and a good program from any standpoint you want to take it. I have made the suggestion--or, rather, I would like to make the recommendation--that WACs can be utilized in reconditioning.

MAJOR CRUZE: There are two or three things that I would like to mention. In the first place, with reference to on-the-job training, or as in our ASF training service, we call it, instructor guidance program. In so far as instructors are concerned, if any inspector from a Director of Military Training office ever went into one of our training centers and failed to find an instructor guidance program in operation, he would raise cain in no uncertain terms.

In other words, that is as much a part of the operation of a training center as the program of training that is set up for the trainees who are being given their basic training. And the instructor guidance program must be made out in detail, must be approved and every hour must be scheduled. That is the only way that we can make our training centers and our units operate effectively. We can't possibly conceive of a training program operating without that sort of thing for the instructors.

Now, then, with reference to personnel, the only personnel that the Director of Military Training is concerned with in this program will be your trainer personnel for the Convalescent Training Program.

I should like to read to you the two or three paragraphs dealing with personnel which were contained in the directive that went to the Service Commands from our office on the 29th:

"Enclosure No. 3 is a table showing suggested personnel utilization for the operation of the Convalescent Training Program. This table is not intended to provide exactly for the actual needs of any particular hospital, but merely intended for use as a guide in setting up a convalescent training program. Qualified civilian personnel will be used instead of military personnel wherever practicable. It is anticipated that some courses may have few or no students while others will be selected by such large numbers of patients as to require more instructors than indicated on the suggested table. Necessary adjustments in the number of instructors for the various courses must be made on the basis of the experience obtained in the operation of this program. The personnel required should be obtained from sources available within the service command."

"Personnel which cannot be obtained in this manner may be requisitioned from the Adjutant General."

Now, as I told you yesterday, the very minute that a requisition hits The Adjutant General's Office for any of this instructor personnel--by instructor personnel I mean those listed from here on down on this chart which you have (indicating the technical instructors)--any time a requisition for any of those men comes

to The Adjutant General's Office, our Training Requirements Division will receive it and will go to Military Personnel and will say to Military Personnel, "Now, here we have a 296 at such and such a training center. We will pull him."

"We have an 014," "or we have lots of 014's over here," we will say, "at Aberdeen." We have this man there and this man at the other place. We will pull these men and make them available.

Then, Military Personnel Division will order these men, these specialists, to report to the service command requisitioning them. In other words, we are going away out of routine to make sure that you do have the technical specialists that you must have if this training program is going to operate.

Many of these men may never have been in a hospital. I mean it is entirely possible that they haven't even had a sore toe to be bandaged. Once they come to you, then, your instructor guidance program is going to have to indoctrinate these men in the type of work they are going to have to do there. They have been serving as instructors and automechanics in an automotive school somewhere, or in an ASF training center somewhere. They know automotive mechanics and they know how to instruct. They don't know anything about the Convalescent Training Program.

We can assure you that you will be able to get these men. We can't assure you that you will be able to get any of the other "spec" serial numbers listed in the table.

In other words, that is not our responsibility. We will not assume it. We know nothing at all about the operation of the hospital. We do know something about the operation of the training program. And we know where to find these specialists, and we will go after them for you.

Now, if you have in the ___ service command a hundred thousand personnel authorized, and you have a hundred thousand present, and you requisition ten, then, you are going to have to get rid of 10 that you do have. In other words, these men that we obtain for you will have to fall within the personnel authorizations that you already have. We will try to get you good men. As I say, we will know that they are capable in their own specialty. They won't be qualified in reconditioning. From there on out, it is up to you, but when a representative from our office comes around to look over your Convalescent Training Program, one of the very first questions he is going to ask you will be this: are you operating an instructor guidance program for these instructors whom you are going to have in your technical courses. And I hope your answer will be yes.

MAJOR BRISCOE: There are a lot of people in a hospital, a lot of intelligent people. The staff of the hospital would compare in training and ability with the staffs of most colleges. I visited a hospital on the West Coast recently where I spent a good deal of my time. I went into one ward and the nurse took me around and showed me very proudly a number of things going on in those two wards which she had been working in, which she herself had gotten started in her regular duty rounds I found doctors in hospitals who are interested in participating in this program who have never been asked to do a thing. I remember sitting one Sunday afternoon litening to a physician tell me about Sourth America. He had spent two years down there. His wife was a foreign correspondent and his family was residing in Mexico City. He knew more about South American affairs than any man I had ever talked with and yet he had never been called upon to make any contribution in the hospital.

The film we saw yesterday showed one officer in the hospital program, who was also Plans and Training Officer for the hospital. The program was run entirely by patients and I must say it was as effective as any Class 1 and 2 program that I had seen anywhere in my inspections in this country.

MAJOR GLYNN: We want and we expect you to accomplish the desires of General Somervell as expressed in ASF Circular 419: that is our mission.

As I said earlier, our division is not an operating agency. We have developed a plan for the care of patients at convalescent hospitals. It is not perfect. There are going to have to be modifications made in the light of practical experience, but it is your responsibility now and it is up to you people to make it work and we will help as much as we possibly can. I think a month ago most of you --most

of us, rather--would have said that there were obstacles in the path of this program that were well nigh insurmountable. Over night a change came, and we could see that this plan could become a reality. Now, I don't see how any program that has the wholehearted support of the President of the United States, the Secretary of War, General Marshall, General Somervell, and General Kirk, can fail.

We all have a military obligation to make it work. Some of us are physicians. We have the further obligation of a physician to his patient to make it work, and I am sure you all will do everything possible, and I wish you every success. Col. Thorndike would like very much for the representatives of the Convalescent Hospitals to bring any plans, diagrams, or data, which would be of general interest to the meeting this evening. Bring it here just prior to 7 o'clock, so we will have a chance to look it over and assemble it in some form.

COL. THORNDIKE: We have arranged this period in the conference so that you can get all the questions off your chest. I am going to turn this meeting over to Major Briscoe who has collected the written questions and who will conduct the program.

MAJOR BRISCOE: There were one or two questions regarding buildings on the program which were not answered, I believe, fully.

I asked Major Ransopher to get together some suggestions for planning shops giving the percentage of patients that might be expected to enroll for the different shops, together with some formula for figuring the required classes, the number of teachers required and the number of shops required.

Major Ransopher was for a number of years Assistant Director of CCC Camp Education throughout the country and their problems were very much similar to those you are facing.

MAJOR RANSOPHER: Gentlemen; this program is not entirely a new program for The Surgeon General's Office.

If you will go back over the records at the close of World War I, you will find that a similar program was carried on in 1918 and 1919, and that in The Surgeon General's report at the close of that program he found that the vocational training had a very favorable effect on the trainees, and recommended its continuance in certain phases.

We are embarking on a program that I expect, at this stage of the game, has left some of you quite confused. We are about at the place now that a family is in planning a new house, and they have pieces of plans lying all around, and the whole picture is still not a composite one; it is a sketchy picture, and I thought perhaps we might spend a few minutes this evening touching on some of these points that might help you pull these ideas together.

There are a few points that have been mentioned, but only rather lightly, that I would like to take up and go into in a little more detail.

One of these is orientation. The reason I mention that: Major Briscoe mentioned that I have had some experience with the CCC. We found that poor orientation caused us severe losses in personnel in the CCC, and I think we are going to find that same thing in this program.

The impressions a man gets when he enters a camp,-- and the same thing I think will hold true in hospitals, - and the habits that he forms over the first week or ten days are the ones that persist.

I am going to make just a few suggestions.

Probably you are carrying out a lot of them at the present time, but a few suggestions that follow the pattern that we use in the CCC orientation program.

One of the things seems to be a simple thing -- we finally developed a rule that no matter what hour of the day or night new men came into camp, they got a hot meal the first thing upon arrival.

Perhaps the patient has been on the train all day or all night, or for some time, when he comes into the hospital; if immediately you give him a hot meal, he says, "these people are pretty thoughtful." It is a small thing.

Then, next, we commence to inform the man that this was a place that people were trying to do the maximum for him. That was done through talks, through visits out on the work job and in the case of the hospital when we get these shops established they can be taken to the shops and show them the opportunities that exist in that hospital.

Of course, the use of movies, and talks by other patients, talks by officers, sell them on the educational courses and the possibilities that there are. We speak about, for instance a course, in printing. Now to the instructor that means a very definite thing but it may mean an entirely different thing to the trainee. If you have a check list that shows the man about what he is going to get out of that course, that you can give him, perhaps even display on the bulletin boards, then he knows what he is going to get out of a certain unit in printing, or a certain unit in music, or whatever it is. And it is one of the things that gets attention and then later interest.

One of the things that I suppose will be worked out later is some productive work which will be carried on in the camps. Production jobs and projects that will be made in the shops are to be discussed with these men.

Along that line is another little devise that may be helpful: It took us three years to learn this in CCC.

We had correspondence courses from about 40 State universities and about 45 private institutions offered for CCC boys. Yet, there was only a small percentage that took advantage of those courses.

Finally, some bright fellow fixed up a study room that was supervised, where he had the reference material and he stimulated those boys a little bit that were taking these courses and the first thing we knew we commenced to establish these supervised study rooms and it wasn't long until we had about 25,000 men taking correspondence courses. The whole secret of that was a place where it was quiet, well heated and lighted, with reference material and other material for the men to use and a supervisor who could help out if they needed guidance.

Sell a man on facilities.

I noticed the Colonel mentioned in his talk the necessity for making things attractive around these hospitals and shops. I am a believer in the fact that men who are to be reconditioned deserve just about the best that a rich country can give them. As far as I am concerned, they are going to get all the equipment and every other thing that we can get for them. I think we ought to make the classrooms, the shops and day rooms just as attractive as possible. I think we can certainly do that.

A few other little points: After all, this program is a program for exploratory purposes mainly. That is, to help these men find their vocations. One of the things that will be helpful, I believe, will be to make available to them a good many trade magazines. There are magazines that are published in every different field today -- in foods or furniture -- and I think that probably 50 or 100 of these magazines around in the reading room will be used and used very profitably by these trainees.

The educational materials in the way of training manuals and so on, that the Army has, I think will, of course, be available and they are excellent.

A few other points that I have noted down here that are mainly of interest to the service command representatives and the hospital commanders:

At this stage of the game, it appears that your first problem is to secure the directors, and next one of the officers who will head up each of these various shops -- that is, the graphic arts, commercial, and so on. It appears that the next step would be to prepare estimates as to the number of students that you will probably have in each class of work.

The fourth step: From those figures you can prepare estimates on buildings. Probably a lot of you have already passed all through all these stages. After that an inventory of present buildings, and check against needs, then an inventory of equipment -- and check those against the tables of allowance; then immediately requisition your buildings and the equipment that you need.

My suggestion is: Get that done quickly, if you can.

MAJOR BRISCOE: The first question which has been presented is this: ASF Circular 419 states that O.T. will be conducted in convalescent hospitals as a functional activity for physical injuries and neuropsychiatric disorders, and yet Chart 2 lists an arts and skills group functioning under O.T., and Chart 4 lists hobbies and diversional activities as part of the program. Is the O.T. to have supervision of the diversional activities too?

COL. BARTON: The reason the term functional was used in the occupational therapy block on the chart was to demarcate it in your minds from the vocational guidance exploratory shop program. That, in a convalescent hospital, is the province of educational reconditioning. As you are aware, in general hospitals, there is an overlapping between educational activities and industrial therapy. There would be an even greater tendency in a convalescent hospital to consider some of these things therapeutic which they actually are.

For clear thinking then, we have reserved the term "occupational therapy" and the function of the occupational therapist, to be solely those treatment activities that are concerned with the development of motion and strength, in orthopedic and neurosurgical cases and the handling of more difficult neuropsychiatric problems.

In addition, however, the usual procedures apply as to arts and crafts activities in the hospital. By agreement, arts and crafts activities in a hospital where there is an occup tional therapy department, will be supervised by occupational therapists.

Therefore, the volunteers procured by Red Cross, the Gray Ladies assigned to the programs, and the arts and skills units which you may recruit to do diversional work, come under the jurisdiction and supervision of the occupational therapist.

MAJOR BRISCOE: This question: "What about a school for physical education course for enlisted WACs?"

MAJOR ESSLINGER: We don't have any enlisted WACS in the physical reconditioning program except in a very limited way in certain hospitals in service training programs.

There are a lot of general hospitals now where the Class 4 program is very large and there might be some work there for a WAC to be employed for a full day at that type of job.

COL. THORNDIKE: I don't think we can go out and say we can't use WACs in our Class 4 program. I think that with the personnel situation as it is today, we must be prepared perhaps to open a school somewhere for WACs the way we have for assistants in occupational therapy at the Halloran General Hospital.

COL. JENSEN: I can say this: That all the students here in educational reconditioning have one hour a day training in physical reconditioning. That includes the WACs, as training is concentrated almost entirely on the Class 3 and 4 and on some of the 2's and the games, particularly the games that are appropriate for Class 3 patients.

So, the WACs that are graduating from this school, have some training in 3 and 4, know the exercises and they can help you with their program.

COL. ALBUS: It seems to me there will be questions, now that we have a training division coming in on us, as to what are the qualifications of the instructors we are using. If, as the signs dictate now, we are going to lose, or at least the prospects are good that we will lose, our presently scarce category trained personnel which we have been able to hold back, unless we do resort to WACs that have certain qualifications.

MAJOR BRISCOE: I take it Colonel Jensen that it would be possible for the school to train WACs in physical education?

COL. JENSEN: The school is giving an hour a day's training in physical education to all WACs.

MAJOR LOUGH: There is another very good reason why WACs should be trained

because we are finding WACs in our hospitals who have been injured or sick and who are entitled to our reconditioning program and it has been a problem to know exactly what kind of physical reconditioning to give them, and we have had to improvise at some places.

MAJOR BRISCOE: I take it from what you are saying and from what Colonel Thorndike has said, that Major Esslinger should take under advisement the matter of training for WACs in the physical education program.

CAPTAIN DITTRICK: There has been some interest expressed in the procurement and training of WACs for physical reconditioning as well as educational reconditioning.

Last July The Surgeon General's Office initiated a procurement request for 300 WACs enlisted personnel which went through the necessary channels to set up the requirements that were set up for education and reconditioning personnel. The total number of requests for WACs following Colonel Gessner's presentation at the Crile Reconditioning Conference ran around 125. At the time those requests were received 175 WACs had been procured. If it were not for the fact the Air Corps was willing to take 75, this 175 that had been procured for education and reconditioning could not have been placed in Army Service Forces Hospitals.

COL. ALBUS: As has been stressed a number of times in this meeting changes have taken place that were not anticipated at the time of the Crile Conference, especially by the hospital commanders. This has altered the situation.

CAPT. DITTRICK: I think the needs should be carefully examined before we go on record for the procurement of WACs.

MAJOR PATRICK: The commanding officer of hospitals will take WACs in the reconditioning program and use them, but there has got to be some kind of procedure worked out whereby they can either live with the nurses or occupational therapists. There is need for some kind of status given to them and some kind of WAC ruling which will allow them to live under conditions that are favorable.

COL. GRABFIELD: One of our biggest problems is getting the enlisted quarters built over according to WAC specifications.

COL. THORNDIKE: It looks to me as though we have to make a very careful survey and I think we have enough material to make that survey with.

COL. ALBUS: Percy Jones is very enthusiastic about WACs. We not only have WACs from the General Hospital of Percy Jones, but we have WACs in our hospital Annex. We have only recently acquired a WAC who was on recruiting duty who had not only her degree from her home university but six years of graduate study in the University of California, and a lot of unusual talents, who fit into our educational program for our hospital annex remarkably.

We have lined up several more for the same purpose. The men like them, they are conscientious and they work hard. We are for them.

MAJOR BRISCOE: I think we have gone far enough on this subject to recognize that WACs have been used successfully in the program but we have to provide proper quarters for them and we have to see that they are trained to do the things that we ask them to do.

MISS MESSICK: I had a conference with Colonel Whitehurst last week, discussing that problem and he said at the time there were 22 general hospitals which have WAC detachments and that it was anticipated that there would be WAC detachments at all the general hospitals.

MAJOR BRISCOE: There are enlisted men available within installations with physical education degrees. Would it be possible to send these men to OCS and have them returned to service commands with the view of assigning them as physical education officers?

CAPT. GRACIE: We can take any properly qualified applicants, make arrange-

ments with Major Dextrow to handle the assignment of WAC officers and get them back to you.

The one thing that we do ask is that they be qualified officer material first.

We have had a great deal of difficulty at Barkeley and at Carlisle with men who had specific qualifications, but did not have the primary qualifications of being officer material.

MAJOR BRISCOE: What about the use of prisoners of war -- as firemen, K.P.'s, and general cleanup details?

MAJOR GANSLOSER: I would say we would find it very difficult to operate if we hadn't had our detailed PW's. They have done an excellent job and we are using about 250 PW's. They do KP, labor detail, landscaping.

MAJOR BRISCOE: Will the members of the band be able to teach the instrument indicated in the detailed programs of instruction? We have four representatives here of music. Captain Soderberg and Captain Thayer of the Adjutant General's Office and Lieutenant Marriner and Lieutenant Lyon of the Special Service Division.

CAPT. SODERBERG: I will turn that question over to Captain Thayer, who is in charge of the Band Training Unit.

CAPT. THAYER: In considering our entire music reconditioning program, we must keep in mind at all times what Colonel Barton said: That the music program is not a glorified form of providing entertainment -- just "something for the boys" -- by an emotional route. It is the express duty of the musicians of the band assigned to the hospitals to be prepared to help the patients in patient participation.

At the band training unit at Camp Lee where we are training the bands for Army bands here and overseas, we have a great many men continuously going through. If you find some of your personnel of the bands who cannot perform the duties which you wish, in line with the policies, we shall make every effort to screen through our men and to effect a training whereby the musicians that you have may be sent to us and in turn sent to some overseas band or some other organization where playing is the only job, and find for you some men who have the educational background and the desire to render this type of service.

LT. MARRINER: I have been working in hospitals for several months, and we have managed this way. If you will look in Chart 5 in Circular Letter 419 you will see music as one of the educational activities. Major Gwynn this morning spoke of music as being recreational. Yes, it is, but it has educational advantage as well. When making a survey at the beginning of 1944 we found at Halloran we could establish a music workshop with several cubicles -- seven in all, which were sound proof. Less than eight months ago that workshop started functioning, and the figures were very rough but since then in less than eight months 1500 music lessons have been given and over 700 different men have been in to use the music workshop. Lessons have been given through and by cooperation of the Red Cross with the Music Council of teachers from New York.

That has not even been advertised around the ward. Many of the men haven't found until they were in the hospital a month or two that there is a music workshop.

At Mitchell Convalescent Hospital we found that there is a real value of establishing a music shop in one barracks 20 x 100 and another 20 x 50 because these were needed. A rehearsal room, a classroom, at least three cubicles, a musical instrument storeroom with shelves, adequate repairing facilities and an office, and the other building a music appreciation room and a music study room.

Now for personnel, in every case that is now in the hospitals, that is in general hospitals and in the convalescent, the Red Cross is cooperating, the band men are assisting in giving lessons and so are the Red Cross Gray Ladies. We have worked together in this thing and the assignment of two technicians, musical men, from the SCU detachment, we have been able to find only by screening them. These men must be adjustable. They must have leadership and musical background. They must have civilian experience in teaching. They must have the personality and the

enthusiasm and initiative and a great deal of imagination to go after these men.

Results show themselves in the music workshop in less time than it takes to tell the story.

We have had MP's come in there and in less than a few hours are back in the groove again, when they have been completely unfitted for anything else that perhaps the reconditioning program has had to offer.

CAPT. BUCKELOW: I think there are two basic considerations of music that we have to keep in mind -- psychological rehabilitation and resocialization. You will find both of those words in Mr. Roosevelt's letter.

In the first place, we must not allow ourselves to fall victim to some of the bad publicity that has been given music in some of our institutions. Think of music not as a therapeutic procedure at all. It does not need to be dragged down in the realm of pus and blood to be judged. It stands now where it always has been -- in the hearts of men.

Let us therefore keep in mind that as we establish these music classes, that we shall not play music for the sake of playing, or for intent, but let's build our music around the theme of teaching as an educational process.

In the light of the experience that we have had at Cushing, I would urge that you not overlook the very valuable effects, not only from the standpoint of entertainment, education, job families, recreation, there is no activity that you will carry on, whether it be physical education through the cadence of well-timed music, or whether it be a part of a church service, or whether it be the last notes of a funeral, there is no activity involved in our business here that cannot be enhanced by properly chosen music.

CAPT. THAYER: There will be quite a demand for string instruction and piano instruction.

Unfortun tely, the table at the present time set up, the manning chart, does not provide for technicians who can teach those instruments.

If out of your full band there are no technicians available to take care of of the string courses, I think The Adjutant General's Office can assist materially in making the exchange and of providing the properly qualified personnel.

MISS VINCENT: Pending such time, I do hope that you will try to secure the services of volunteers and let us try to secure the services of volunteers for you.

CAPT. THAYER: I think we must be very careful to accept, as far as general plans go, only those procedures which have been tested and proven to be workable by such music officers as Lieutenant Marriner and some of the others who have been working with him, and remember that these men that were under our care, are not subjects for any unproven schemes that may come along.

MAJOR BRISCOE: "What can you musicians do in your program for an ordinary dumb cluck like myself in music? I can't play an instrument or anything. There are a lot of those men in the Army. Can you do anything for them?"

CAPT. THAYER: Yes, sir. Another thing which the bands of the hospitals must remember: that whenever the two questions come up as to whether the musical perfection of the production, or the interests of the patients are to be sacrificed, then production must be thrown out of the window.

If a convalescent soldier who always wanted to play a coronet way back there in civilian life and never had a chance, can get enough instruction -- and he can do it in a few weeks -- to blow out a tune of "Home Sweet Home" or any simple melody, you have given him a step forward on the road to recovery and self-confidence, and I think that at all times we should be alert to give these gentlemen-- and the ladies too that may be in the hospital -- the instruction.

It was that that I had in mind when I mentioned substituting the qualified string and piano instructors for some of the men.

COL. JENSEN: The most common useable musical instrument in the world everyone carried with him in the form of larynx and they put together each month out of the classes that come here a wonderful chorus. I am sure it can be done in the hospitals

You will have to realize that the reason most of us didn't learn to sing or the reason many of us didn't learn to play a musical instrument is that about that time somebody brought a radio in the house and it made the music for them. But the men enjoyed it very much.

The instrumental side is very important. You need it.

COL. BARTON: In conversation with The Surgeon of the Fifth Service Command he asked if Captain Neeley might not be sent to this conference to tell us something about a scheme which he had developed at Fletcher for the development of educational reconditioning materials.

CAPT. NEELEY: For two months, after having graduated from two courses of Colonel Jensen's fine school here, have run a program of reconditioning in a 1500 bed hospital alone, and I concur with my colleague, Captain Lyon, when he said that a reconditioning program is one of the most difficult jobs, one of the toughest jobs that any man could ever hope to tackle.

The materials that have been developed by the Information and Education Division have been outstanding and excellent. However, the chief use of these materials is in the one-hour orientation period which is required of all troops and the off-duty discussion periods that are used in some military units. The orientation and discussion program in a hospital has become a daily program. Consequently, more materials are needed for the hospital programs. The development of these materials must be in conformance with the doctrines expressed in WD Pamphlet 20-3, but it is believed that these must be suited to the needs of the specific hospitals. In order to expedite the development of these materials in our service command, the following plan was evolved and is presented for your information. It is understood that the distribution of any material of this sort in a service command must be cleared through G-2 and PRO.

A Proposed Educational Research Bureau for The Fifth Service Command

A. Purpose

To produce and disseminate educational materials to all hospitals in the Fifth Service Command.

B. Advantages

1. Would eliminate duplication of effort. All materials could be prepared at this center, and not at every hospital as formerly.

2. Would serve as a testing ground before dissemination. This procedure should improve the quality of the materials and help make them more attractive to the patients.

3. Would help improve the educational program at all hospitals. Specialists would be devoting full time to this project, aided, perhaps, by contributors from the field.

4. Would serve as a clearing house for progressive ideas and the best materials from this and other service commands.

5. Would encourage individual initiative. Names of all contributors could be listed.

6. Would relieve the under-staffed, over-worked education units of much, or all, of this particular work, thereby giving them more time for administrative duties.

7. Would boost morale. This project would be intangible evidence to the

men in the field that our Chief is doing everything in his power to help them put the program over.

8. Would eliminate the necessity of collecting a large library at each hospital. The books of this complete library could be loaned to those in the field upon demand.

9. Would standardize our educational program.

10. Would assure advance approval of materials by all concerned, especially the patients, the commanding officer, and the public relations officer.

C. Personnel

1 officer, Captain or Major, to serve as Chief or Director.
6 enlisted men to assist in research and preparation of materials. One of these should be librarian; three should set type and operate printing press; two should devote full time to research and to checking popularity of materials with patients and reconditioning staff.
1 secretary to take dictation, transcribe, cut stencils, answer routine correspondence and mail out materials to various hospitals.

D. Equipment & Supplies

1 complete library kept up to date. Loans could be made.
1 printing press or mimeographing machine.
2 typewriters. One for secretary and one for researchers.
Adequate supply of paper and office supplies, furniture, etc.

E. Location of Bureau

It is recommended that it be established in the field where materials can be tested before dissemination. If relatively close to Fifth Service Command Headquarters, liaison would be good. As Fletcher General Hospital is near Columbus, and as it has reproduction facilities, which soon will include a printing press, it might be a good location.

F. Miscellaneous Services

Although this particular bureau will originally produce educational materials for discussion groups only, it may, upon demand, be able to render other services, such as: preparing film strips; previewing movies to insure wise selection and dissemination; publishing a Fifth Service Command Reconditioning Newspaper; etc.

MAJOR BRISCOE: Is it contemplated that you are going to use something like this in your service command?

COL. PRESTON: What we were thinking of was to have the materials prepared in the various hospitals and sent through the educational officer in the headquarters of the service command, hoping that we would not have such spotty discussion materials.

MAJOR BRISCOE: In other words, your plan is to bring it out in the field, screen it, and then standardize some of the materials?

COL. PRESTON: Yes. And we will probably reduce to about 10 to 15 percent the amount of work necessary in the field for the various hospitals. Once we get a good volume of material having been screened we can send it back out to the various hospitals, and perhaps save a lot of the original research work.

MAJOR BRISCOE: I can say this: That from the point of view of curriculum development or techniques of curriculum development your plan is entirely sound.

COL. JENSEN: I think there is something here we ought to think about. By War Department direction, ASF has the responsibility for developing an approval of all this type of material. That material, incidentally, is all checked by G-2. We have got to be pretty careful when we get into this field. Very careful that

we put it down on paper. Because you will be in very deep conflict if you are not. It is just a point to keep in mind.

MAJOR BRISCOE: Do you find the discussion guides that are sent out by the Information and Education Division helpful? They are sent out regularly — fact sheets.

CAPT. LYON: We have utilized all that I & E produce, but you well know if you are going to have a discussion every day, I & E hasn't produced enough material.

What actually happens is that about half of the week the discussion programs are going to have to be improvised on the ground. That is, somebody there has got to do it.

MAJOR BRISCOE: May I say that the I & E Division have produced, I think, 17 or 18 units on three different subjects that are now in process of being printed and will be out in your hospitals very soon.

Three basic subjects are: "What is propaganda; what is fascism; what are democracies?"

And, following the publication of this material, there will be published at regular intervals, content material which we believe will be of help to you. That material has been approved. It is produced and I am sure it is in process of being printed right now and will be out to your hospital soon.

CAPT. HALL: It is the responsibility according to AR 210-70 of the post librarian to provide supplementary and educational materials for any educational program that is in progress. That would apply to hospitals as well.

I wonder if you have asked the librarian for help and if she has refused, will you please let me know and I will see what I can do about it.

MAJOR BRISCOE: I think that applies to all service commands.

MR. MORROW: May I, with your permission, relate our experience with reference to film materials. I think it has a bearing on the Captain's point there.

In recent conferences with I & E in attendance with Major Briscoe, we realized that we people in reconditioning have an educational program to conduct. I & E is charged with the responsibility of the Army Education Program as a whole. However, in reference to film materials, The Surgeon General for the Reconditioning Division, will have the right to select the materials which apply to the educational reconditioning program as a whole, and I & E will tell The Surgeon General whether or not those film materials are contrary to the War Department policy adopted.

If they are not contrary to the existing policy adopted they will be ordered and distributed to the commands.

CAPT. LYON: I would like to put a very practical problem.

Using all of this material that I & E is using we will not have enough to meet this one hour of discussion that is laid down in 419. What are you going to do about it?

MAJOR BRISCOE: It isn't our intention in 419 that you shall spend one hour a day necessarily talking about the war, its issues, the problems of peace and so on.

CAPTAIN DITTRICK: It is not intended as pointed out that five or six days a week be devoted to discussion groups along the broad aspects of education and information.

If the needs of the various groups of patients are going to be met, if they are going to be met in the hospital program, use some of this time which we might refer to as general education and general informational subjects, with related information to the vocational guidance program. That is, these films that have been reviewed and approved cover quite a wide range of vocational interest, and related to the exploratory aspects of the program. There are other film projects which are in the mill so to speak in The Surgeon General's office, in evaluating films, in attempting to develop certain programs.

Where we may relate to the I & E mission they do have the concurrence of I & E as Mr. Morrow has pointed out, but we look to this one hour per day as something expanding over and beyond what has been the discussion program up to the present time.

COL. BARTON: In reply to Captain Lyon and Captain Neeley, anyone who has seen the educational reconditioners at work, knows what a laborious task it is to keep a current file operating on topics that are necessary for daily use.

I wonder whether you aren't telling us that what you would like to do is to send us units that you have developed that seem appropriate for your use in the field from your field testing, and have us get clearance for it, and publish it so that it will be available to others.

MAJOR PATRICK: You would get into all kinds of copyright problems there, with the source from which the material comes.

We worked it out at a number of hospitals by posting on the bulletin boards a number of topics, and then letting the men go by and check the topics that they wanted to discuss.

Take one of these studious persons the Captain speaks about and let him run down the content of the subject matter that has been written on those topics, then pass it around and let the men read about it and then have two or three of them prepare to comment on each aspect of the topic. And it works out, with a little ingenuity; I see no serious problem there of keeping continuous with a lot of information.

MAJOR JUSTER: The Chief of the Educational Division at Mitchell has arranged with the San Diego Chamber of Commerce to get some industrialists in with information regarding post-war jobs, and, when I left, we had 32 lectures, arrangements were being made to have them come in; we will preview the film to see if it is all right (if they have the film with them) and have them give a talk to the discussion group.

MAJOR BRISCOE: That is an excellent point. I think Colonel Jensen's caution was mainly on the matter of publishing this material.

LT. KISKER: I think we are overlooking one possible source of material that has possibly been developed during the last two months, to a greater extent than any of the other programs.

The education department is going to give the vocational training. The classification and counselling is going to give the vocational guidance. Together they work for the evaluation of the patients' interests and skills.

Now, to give such guidance you need a substantial supply of materials, educational, occupational, vocational.

To meet that problem we have worked out a system whereby an occupational and vocational materials unit has been established, one in the special services division --that is, in the library section in New York City -- and the other in The Adjutant General's Office.

The materials coming from The Adjutant General's Office will relate to the counsellors. It will be counsellors orientation material. It will be pitched at a different level from that coming from the materials unit from the library section.

That material will be for the use of the soldier. You see, there are two problems there: The orientation of the counsellor and the orientation of the soldiers.

Both of these programs are being developed on a large scale.

Just prior to the conference I spent thirty days in New York in a conference with such organizations as the National Association of Manufacturers, American Management Association, the Russell Sage Foundation, 20th Century Fund, the Society for the Advancement of Management.

We are working now in cooperation with some 15,000 industrial organizations to supply various types of material that might be of interest in this program.

MAJOR BRISCOE: Will that be sent into the hospitals or will it have to be requisitioned?

LT. KISKER: The details of that will be worked out. Most of that when possible will be sent automatically to the installations. That is for the larger program of separation and classification in all hospitals, but it fits admirably in this convalescent hospital program and the materials will be forthcoming there.

Now, on the counsellor level. We have already set up a relationship with War Manpower Commission, the Bureau of Labor Statistics, the Office of Education, the labor organizations, CIO, AFL, Railway Brotherhood, industrial relations groups, all on a national scale anticipating the use of this material in all Army hospitals, AAF and ASF.

That material will be available at both levels in the hospital situation in the convalescent program, and it certainly will help out on a number of these points that have been brought up.

COL. THORNDIKE: I want to call your attention to some of the exhibits the hospitals have put up around the front of the room here. Some of the hospitals have brought some of their material, some of their charts, and some of them are indeed very interesting.

We haven't space to put them all up but if those who haven't put their's up have them with them, I am sure that some of you would like to stay and see what is being effected in the field?

COL. BREWER: Is there anyone here who can tell me how to get help with my PA system?

MAJOR LOYE: That program with the public address systems has been developed and has to be carried out under the allocation of materials from the Signal Corps to see that not more than the strategic materials can be used in this overall program. That is a special arrangement of central procurement of those materials and are purchased from non-appropriated funds available to the different installations.

MAJOR BRISCOE: Would you advise Colonel Brewer on that more in detail later?

Now, as to your question, "How do you get a band?"

CAPT. SODERBERG: We have eight of the convalescent hospitals furnished with bands at present, and I understand that a band will be assigned.

COL. THORNDIKE: I think that this conference has led us a long way ahead. I think we have all learned, as far as our division goes, much about the problems in the field. I think that you in the field have learned something about this new convalescent hospital program. Remember this: That the convalescent hospital is a new type of medical installation. We have given you charts, manning tables, supply lists, which we think are adequate, but which we know will be changed to suit individual needs, and inasmuch as this the last opportunity we will have to get together, and tomorrow will be devoted entirely to the school and its reconditioning department, I want to express to you gentlemen, on behalf of The Surgeon General, that we appreciate very much the time you have given us and the discussion you have produced.

MAJOR BOYNTON: I will make a resolution that we express our gratitude for the extraordinary hospitality shown by the school at this conference.

COL. THORNDIKE: You hear the resolution. What is your wish?

A VOICE: Move it be adopted.

COL. THORNDIKE: All those in favor say aye.

(Aye)

COL. THORNDIKE: Contrary minded.

(None)

COL. THORNDIKE: It is unanimous.

Thank you.